

No. 300  
1-10-47  
5-17-39  
I 3906

FILED NOV 6 1948 318  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3519 Sidney St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3519 Sidney St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Iolantha Pearl Kinder

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27,  
year 1948 hour 8 minute 05 P. M.

21. I hereby certify that I attended the deceased from 6-1-1948  
to 10-26-1948  
that I last saw her alive on 10-26-48  
and that death occurred on the date and hour stated above.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 8, 1883  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

Immediate cause of death Autointoxication and Paralysis of throat. Non-diphtheritic

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 115  
(Include pregnancy within 3 months of death)

9. Birthplace White Hall, Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Secretary

11. Industry or business Barry Motor Company

12. Name Joseph G. Kinder

13. Birthplace Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah E. Anderson

15. Birthplace Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Kinder

(b) Address 3519 Sidney St.

17. (a) Cremation (b) Date thereof 10-28-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Weick Bro. Und. Co.

(b) Address 2201 S. Grand Bk.

19. (a) OCT 27 1948 (b) J. B. Lasater  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature Dr. Clay Allen (M. D. or other)  
Address 5912 So. Kingshighway Date signed \_\_\_\_\_  
Dr. Rubin mo

PHYSICIAN  
Underline the cause to which death should be charged statistically.

*In Allen  
5912 S Kings*

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *James R Dunn*  
- - Licensed Embalmer No. *4527*  
P. O. Address. *2201 Grand*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**