

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28220

#65511

State File No. 6897

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. _____

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1. | | d. STREET ADDRESS (If rural, give location) 1034 Forest Avenue | |

| | | | | |
|--|-------------|-----------|--|--|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| a. (First) | b. (Middle) | c. (Last) | August 8th, 1949 | |
| THOMAS Francis KANE | | | | |

| | | | | | | |
|----------------|---------------------------|---|----------------------------------|---------------------------------------|-----------------------------|-----------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH May 26, 1871 | 9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months 2 | IF UNDER 12 HRS. Days 12 |
|----------------|---------------------------|---|----------------------------------|---------------------------------------|-----------------------------|-----------------------------|

| | | | |
|--|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Grand Tower, Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|-----------------------------------|--|--|

| | | |
|---|--------------------------------------|--|
| 13a. FATHER'S NAME Thomas Francis Cain | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Louisa Kroeck |
|---|--------------------------------------|--|

| | | | |
|--|---------------------------------|--|---------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Mrs. E. J. Oehler | ADDRESS 1034 Forest Ave. St. Louis |
|--|---------------------------------|--|---------------------------------------|

| | | | |
|--|---|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|---|

| | | |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 |
|--|--|---|

| | | |
|---|--|-----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 2 X |
|---|--|-----------------------------------|

22. I hereby certify that I attended the deceased from 7/21/49 to 8/8/49, that I last saw the deceased alive on 8/8/49, 1949, and that death occurred at 12:30am, from the causes and on the date stated above.

| | | | |
|--|-------------------|--------------------------------------|----------------------------|
| 23a. SIGNATURE <u>Joseph J. Mendenhall M.D.</u> | (Degree or title) | 23b. ADDRESS 1515 Lafayette Ave., | 23c. DATE SIGNED 8/8/49 |
|--|-------------------|--------------------------------------|----------------------------|

| | | | |
|---|-----------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery | 24d. LOCATION (City, town; or county) (State) Saint Louis County, Missouri |
|---|-----------|---|---|

| | | | |
|-----------------------------------|--|--|-----------------------------|
| DATE REC'D BY LOCAL AUG 8 1949 | REGISTRAR'S SIGNATURE <u>J. B. Luster</u> | 25. FUNERAL DIRECTOR'S SIGNATURE Ambruster Mortuary | ADDRESS 6633 Clayton Rd. |
|-----------------------------------|--|--|-----------------------------|

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Ernest W. Spillers*
Licensed Embalmer No. *4080*

P. O. Address _____

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.