

FILED SEP 22 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

31753

State File No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7739	
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 town) ST. LOUIS		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) 2119 OR TOWN ST. LOUIS		d. STREET ADDRESS (If rural, give location) 2429 FALL	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2429 FALL AVE				d. STREET ADDRESS 2429 FALL			
3. NAME OF DECEASED (Type or Print)		a. (First) INEE		b. (Middle) KENNEY		c. (Last) _____	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED		8. DATE OF BIRTH Nov 30, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) GRAND TOWER ILL		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME NOT KNOWN		13b. MOTHER'S MAIDEN NAME NOT KNOWN		14. NAME OF HUSBAND OR WIFE THOMAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Flora Marshall ADDRESS 7114 Drury Ave			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ac. endocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial asthma DUE TO (c) Influenza II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4 mo 2 yrs 3 yrs	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 241X			
22. I hereby certify that I attended the deceased from Aug. 7, 1950 , to Sept 10, 1950 , that I last saw the deceased alive on Sept 9, 1950 , and that death occurred at 8:15 A. M. , from the causes and on the date stated above.							
23a. SIGNATURE Boyle Poor M.D. (Degree or title)				23b. ADDRESS 1730th Franklin Ave		23c. DATE SIGNED 8-10-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-14-50		24c. NAME OF CEMETERY OR CREMATORY Railway Cem		24d. LOCATION (City, town, or county) (State) St Louis Mo.	
DATE REC'D BY LOCAL REG. SEP 13 1950		REGISTRAR'S SIGNATURE J B Lasater		25. FUNERAL DIRECTOR'S SIGNATURE A. Kroubilla ADDRESS 2707 St. Louis			

Influenza - three years ago
 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 *Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address *St. Louis*

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.