

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town or township) CLAYTON		c. CITY (If outside corporate limits, write RURAL and give township) 13 OR TOWN Jennings 4130	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hosp.		d. STREET ADDRESS (If rural, give location) 2622 Avie	

3. NAME OF DECEASED a. (First) SALLY b. (Middle) _____ c. (Last) KAIN			4. DATE OF DEATH (Month) (Day) (Year) Sept. 18 1950		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb. 24, 1864	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ruben Owen		13b. MOTHER'S MAIDEN NAME Thurz Ann Hearsey		14. NAME OF HUSBAND OR WIFE John Kain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME Rhoda Kain, 2622 Avie ADDRESS	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) fracture - rt hip		4 mos
	DUE TO (c) Decubitus ulcers		3 mos

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION fracture - hip	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jennings St Louis Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6 1 50 30 PM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell while pulling weeds

22. I hereby certify that I attended the deceased from **6-1-50**, 1950, to **9-18-50**, 1950, that I last saw the deceased alive on **9-18-50**, and that death occurred at **7:07 PM**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS 601 BRENTWOOD CLAYTON	23c. DATE SIGNED 9-19-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/19/1950	24c. NAME OF CEMETERY OR CREMATORY Fulton	24d. LOCATION (City, town, or county) (State) Missouri
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DATE REC'D BY LOCAL REG. 9-19-50	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington
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RWR (Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed William S. Saefer

Licensed Embalmer No. 4699

P. O. Address St. Charles

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

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