

FILED FEB 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4890

State File No. 624

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 624	
1. PLACE OF DEATH a. COUNTY Jackson O				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Kansas b. COUNTY Wyandotte			
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. LENGTH OF STAY (in this place) 1 month		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		8159	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital				d. STREET ADDRESS (If rural, give location) 1506 39th Ave.			
3. NAME OF DECEASED (Type or Print) WILLIAM RILEY CAIN		a. (First)		b. (Middle)		c. (Last)	
5. SEX Male ♂		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 19, 1860	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Hamden County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William F. Cain			13b. MOTHER'S MAIDEN NAME Risbie Bowen			14. NAME OF HUSBAND OR WIFE Rosa Ann Cain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Blaine Cain Kansas City, Kansas			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fractured left femur + senility DUE TO (c) arteriosclerosis of nephros II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fractured left femur - Jan 11th '52				INTERVAL BETWEEN ONSET AND DEATH 4 days E9050 20	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 815				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) Kansas City, Wyandotte, Kansas			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 11th, 1952 4:45 a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell on kitchen floor			
22. I hereby certify that I attended the deceased from Jan 11th, 1952, to Feb 9th, 1952, that I last saw the deceased alive on Feb 9th, 1952, and that death occurred at 5:40 a. m., from the causes and on the date stated above.							
23a. SIGNATURE E.N. Gates		23b. ADDRESS (Degree or title) N. Gillum D.O. 926-E 11th		23c. DATE SIGNED 2/10/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/9/52		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Manhattan, Kansas	
DATE REC'D BY LOCAL REG. 2-9-52		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GATES FUNERAL HOME, K.C. KANSAS			

(Licensed Embalmer's Statement on Reverse Side)

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

THE BOARD OF HEALTH OF MONTANA
STANDARD CERTIFICATE OF DEATH

Dr. Myron
Osteopathic Hos
11th + Harrison

Form with multiple sections for recording death information, including fields for name, date, time, and location. The form is mostly blank with some faint text visible.

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 *Jimmy S. Hubsher*
Licensed Embalmer No. *4092*

P. O. Address *Missoula, Mont.*

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.