

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6420

FILED MAR 15 1954

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2089**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2119	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. CITY OR TOWN St. Louis	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 1907 Bacon Str.	

3. NAME OF DECEASED (Type or Print) Evay Icie Kinder.			4. DATE OF DEATH Mar. 4th. 1954		
a. (First)	b. (Middle)	c. (Last)	Year	Month	Day
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 20. 1895	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days
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 (City and State or Foreign Country) Polk County Ill /	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME Green Shelton.		13b. MOTHER'S MAIDEN NAME ??-Sturgeon		14. NAME OF HUSBAND OR WIFE Irvin Kinder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Irvin Kinder 1907 Bacon Str.	
				ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a); (b); and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) Cerebral Apoplexy			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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)		
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? 334x		

22. I hereby certify that I attended the deceased from 18 1954, to 19 1954, that I last saw the deceased alive on 6/10 1954, and that death occurred at 6:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE Patrick J. Taylor Coroner		(Degree or title)		23b. ADDRESS 1500 Clark		23c. DATE SIGNED 2.6.54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 8th. 1954		24c. NAME OF CEMETERY OR CREMATORY Kennett Mo Cemetery		24d. LOCATION (City, town, or county) (State) Kennett Mo	
DATE REC'D BY LOCAL REG. MAR 6 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Hy. Leidner Und. Co		ADDRESS 2223 St. Louis Ave.	

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.....
Signature of Student Embalmer

Signed *John J. Harris*.....

Licensed Embalmer No. *410*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.