

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20756

4717

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 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, MISSOURI			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN ST. LOUIS, MO.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL				e. STREET ADDRESS (If rural, give location) 1816 (Rear) Franklin Ave. 2219				
3. NAME OF DECEASED (Type or Print) a. (First) EMMA		b. (Middle) _____		c. (Last) KAIN		4. DATE OF DEATH (Month) (Day) (Year) MAY 26, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 1, 1873		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____	IF UNDER 2 HRS. Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME DAVID MORTON			13b. MOTHER'S MAIDEN NAME SARAH COOK		14. NAME OF HUSBAND OR WIFE Charles Kain			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles Kain, 1816 Franklin 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, primary unknown ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Broncho pneumonia DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1999				
22. I hereby certify that I attended the deceased from 5-1-54 , 19____, to 5-26-54 , 19____, that I last saw the deceased alive on 5-26-54 , 19____, and that death occurred at 11:25 a.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Type or Print) Martin G. Austin M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 5-26-54		
24a. BURIAL: CREMATION REMOVAL (Specify) Removal		24b. DATE May 27, 1954	24c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery		24d. LOCATION (City, town, or county). (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. MAY 27 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLAUGHLIN Funeral Home, Inc. 2201 Lafayette St. St. Louis, Mo. Missouri				

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..... *L.P. Cooper*

Licensed Embalmer No. *363*

P. O. Address *2317 1/2 9th*

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.