

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38928

State File No.

10317

Registrar's No.

10317

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN <b>St. Louis, Missouri</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Enroute To City Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>23 1714 California</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>ELLSWORTH</b>		b. (Middle) <b>A.</b>	c. (Last) <b>KINCAID</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>November 11, 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-18-1877</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tuckpointer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Minnette</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>492-16-0953a</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MO. <b>Minnette Kincaid, 1714 California, St. Louis</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____  ANTECEDENT CAUSES <b>Cerebral Thrombosis</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>332x</b>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1030A</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>Patrick Taylor Corcoran</b>		(Degree or title) _____	23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>11-13-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <b>11-15-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Lutheran</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>NOV 15 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLAUGHLIN Funeral Home, Inc. 2301 Lafayette, St. Louis 4, Missouri</b>		

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 *H. G. Farris*.....

Licensed Embalmer No. *338*.....

P. O. Address *H. Lane*.....

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.