

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

2860

193

FILED JAN 25 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1-11-57

| | | | | | |
|---|---------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4353 Koeln Ave. | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) 4353 Koeln Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOHN F. KAIDO JR. | | | 4. DATE OF DEATH Month Day Year Jan. 6 1957 | | |
| 5. SEX Male <input type="radio"/> | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 30, 1915 | | 9. AGE (In years last birthday) 41 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Dep't. - General Analine Corp. | | 10b. KIND OF BUSINESS OR INDUSTRY General Analine Corp. | | 11. BIRTHPLACE (City and state or country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME John F. Kaido | | |
| 14. MOTHER'S MAIDEN NAME Neva Smith | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 2 | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Address (Wife) Marcelle Kaido 4353 Koeln Ave. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM Congestive heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CONGESTIVE HEART FAILURE Rheumatic heart disease DUE TO (c) RHEUMATIC HEART DISEASE | | | | | INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS 4 MONTHS 20 YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) NONE | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4/6 x | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from OCTOBER, 1956 to JANUARY, 1957 and last saw him alive on 6 JAN 57 Death occurred at 1:20 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE James F. Nickel, M.D. James F. Nickel, M.D. | | | 22b. ADDRESS 4952 Maryland Ave ST. LOUIS 8, MO. | | 22c. DATE SIGNED 8 JAN 57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr) 1-10-57 | | 23b. DATE 1-10-57 | | 23c. NAME OF CEMETERY OR CREMATORY St. Dominic Cemetery | |
| 23d. LOCATION (City, town, or county) Breese, Ill. | | (State) | | | |
| 24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway | | 25. DATE RECD. BY LOCAL REG. JAN 8 '57 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. mxb | |

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 *William P. White*.....

Licensed Embalmer No. *512*

P. O. Address *4220 Liberty*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.