

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 18 1957

STATE FILE NUMBER 10406
1799

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. Louis MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Mo 2501 2127</u>		Length of stay in lb	d. STREET ADDRESS <u>5351 DELMAR (If outside, give location) MASONIC HOME OF MO</u>
3. NAME OF DECEASED (Type or print) First <u>ORA</u> Middle <u>KINNEY</u> Last <u>HENRY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1869</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or country) <u>Memphis Tenn</u>
13. FATHER'S NAME <u>Joseph W. Kinney</u>		14. MOTHER'S MAIDEN NAME <u>Belle Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Masonic Home of Missouri</u> Address <u>Levi Robertson</u> <u>District</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>(WITH RIGHT HEMIPLEGIA)</u> DUE TO (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			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.)	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>			
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 <u>Jan. 1956</u> to <u>Feb. 21, 1957</u> and last saw <u>her</u> <u>him</u> alive on <u>2-20-1957</u> Death occurred at <u>6:20 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert A. Hall M.D. D</u>		22b. ADDRESS <u>5381 DELMAR ST. LOUIS, MO.</u>	22c. DATE SIGNED <u>FEB 21, 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-23-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood PARK Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. Louis MO</u>
24. FUNERAL DIRECTOR <u>JAY B. SMITH - Maplewood 17 Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>FFB 21 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u> <u>mgs</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *W. E. Burgess*.....

Licensed Embalmer No. *402*.....

P. O. Address *Maplewood*.....

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.