

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED NOV 15 1957

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 2667

Health & Welfare
Public Service

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits	c. CITY OR TOWN <u>Overland</u> <u>4250</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>O'Sullivan N. Home</u>		Length of stay in 1b <u>2 mo</u>	d. STREET ADDRESS (If outside, give location) <u>10515 Clarendon</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMETT C KINNEY</u>			4. DATE OF DEATH Month Day Year <u>10/28/57</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1875</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days <u>1 2</u>		IF UNDER 24 HRS. Hours Min. <u>0 0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>odd jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>	11. BIRTHPLACE (City and state or country) <u>Blair Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Thaddues Kinney</u>		13b. MOTHER'S MAIDEN NAME <u>Do not know</u>		14. NAME OF HUSBAND OR WIFE <u>Nona L Kinney</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>Nona Kinney 10515 Clarendon</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>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u>					<u>unknown</u>			
DUE TO (c) <u>4221</u>					<u>0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic dementia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <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>Aug 7, 1957</u> to <u>Oct 28, 1957</u> and last saw him alive on <u>10/24/57</u> Death occurred at <u>7:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Lewis Littmann MD</u>			22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>10/28/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/30/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Co Mo</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-28-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Romk MD</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Al C Ostermann*

Licensed-Embalmer No. *3478*

P. O. Address

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.