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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041786
STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10916

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, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Missouri Baptist Hosp — Length of stay in lb 2 days

d. STREET ADDRESS (If outside, give location) 4540 Harris Avenue — Reside on Farm Yes [ ] No [ ]

16 2099

3. NAME OF DECEASED (Type or print) First MARGUERITE Middle J. Last KINNEY

4. DATE OF DEATH Month Nov. Day 12, Year 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH May 23, 1883

9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles Knapp

13b. MOTHER'S MAIDEN NAME Anna Barret

14. NAME OF HUSBAND OR WIFE Wm. J. Kinney, Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 487-26-1312B

17. INFORMANT Mr. Robert Knapp, Address 4540 Harris Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Biliary cirrhosis with ascites — INTERVAL BETWEEN ONSET AND DEATH 2½ weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Choledocholithiasis
DUE TO (c) 584X
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 [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 11-10-58, to 11-12-58 and last saw her/him alive on 11-12-58
Death occurred at 8:48 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Drewn Bailey MD

22b. ADDRESS 10 Theatre Bldg 819

22c. DATE SIGNED 11-13-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11-15-58

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS Stock Mortuary, 2117 E. Grand Bl.

25. DATE RECD. BY LOCAL REG. NOV 13 '58

26. REGISTRAR'S SIGNATURE J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr. D. Bailey
819 Missouri Bldg.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Paul A. Wachte

Licensed Embalmer No. 4787

P. O. Address St Louis

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