

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012797

FILED VS APR 4 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2541** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life	c. CITY OR TOWN Glendale Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1175 North Berry Road Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Dr. Robert Middle Emmet Last Kane			4. DATE OF DEATH Month March Day 1 Year 1960		
5. SEX M.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/18/1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
10c. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME John Joseph Kane		13b. MOTHER'S MAIDEN NAME Mary Belle Sweeny	
14. NAME OF HUSBAND OR WIFE Grace Cantwell Kane		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Mr. Robert Emmet Kane Jr., 1175 N. Berry Rd.		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 insufficiency DUE TO (b) Chronic bronchitis, bronchiectasis, pulmonary fibrosis, emphysema DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 2 years 10 years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 526x			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) 526x			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 February 7, 1960 to March 1, 1960 and last saw him alive on March 1, 1960 Death occurred at 4:10 pm. on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) John T. Lewton, M.A.		22b. ADDRESS 634 N. Grand Blvd.		22c. DATE SIGNED March 3, 1960	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 5, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
24. FUNERAL DIRECTOR Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. MAR 4 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

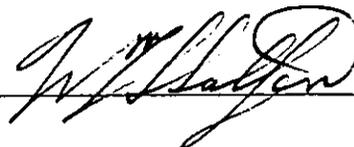
AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Linder

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.