

FEDERAL BUREAU OF INVESTIGATION
FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016671

FILED VS MAY 6 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 4375** 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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in lb 40 yrs	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 617 HAVEN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 617 HAVEN ST Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First THOMAS Middle W Last CAIN SR.			4. DATE OF DEATH Month APRIL Day 20 Year 1960		
5. SEX MALE	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 5/26/1874	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MANAGER		10b. KIND OF BUSINESS OR INDUSTRY GROCERY CO.	11. BIRTHPLACE (City and state or country) CUBA MO	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME MATTHEW CAIN		13b. MOTHER'S MAIDEN NAME CATH McNAUN		14. NAME OF HUSBAND OR WIFE EMMA	
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. 488-05-4421	17. INFORMANT EMMA CAIN Address 617 HAVEN ST.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute glomerular nephritis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bilateral bronchopneumonia	
	DUE TO (c) Senility 491 K	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
---	--	--	--

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 _____ 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 **7/19/54** to **4/20/60** and last saw her/him alive on **4/19/60**
 Death occurred at **3 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. Eades</i>	(Degree or title) M.D.	22b. ADDRESS 7602 So. Broadway	22c. DATE SIGNED 4/22/60
-----------------------------------	----------------------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4/23/1960	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO
24. FUNERAL DIRECTOR JOS. P. FENDLER JR., 7123 MICHIGAN	25. DATE RECD. BY LOCAL REG. APR 22 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mcs

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

V E Morris

Licensed Embalmer No. 3360

P. O. Address, St Louis

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