

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003692

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 265

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Illinois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b	c. CITY OR TOWN Harrisburg
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Parkside Manor, Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Carson Last Kane			4. DATE OF DEATH Month January Day 6 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married: <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1873
9. AGE (last birthday) 89		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Attorney At Law		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Long Branch, Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Robert Carson Kane	
13b. MOTHER'S MAIDEN NAME Mary Elizabeth Mings		14. NAME OF HUSBAND OR WIFE Ethel Kane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No. Nil.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary E. Armstrong, 16715 41st N.E.		Address Seattle, WA	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 1 day DUE TO (b) Arteriosclerotic heart dis. 3 yrs DUE TO (c) Gen. Arteriosclerosis over 3 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) C.P.C. Lungs 420.0 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 Dec. 5, 1962 to Jan 6, 1963 and last saw him alive on Jan 6, 1963 Death occurred at 11:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Shukada, M.D. (Degree or title)		22b. ADDRESS Medical West Bldg	22c. DATE SIGNED 1/7/63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-11-63	23c. NAME OF CEMETERY OR CREMATORY Harrisburg, Ill. (State)	
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd. ADDRESS		25. DATE RECD. BY LOCAL REG. JAN 9 1963	26. REGISTRAR'S SIGNATURE John Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis Mo

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.

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