N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 624
624

Registration District No. 791

Primary Registration District No.

Registrar's No.

FILED FEB 17 1940

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5331 Enright
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DEATHS:

(a) State Mo. (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5331 Enright
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Patterson Bain

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella Ustick Bain

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Feb. (Month) 16 (Day) 1850 (Year)

8. AGE: Years 89 Months 11 Days 5 If less than one day hr. min.

9. Birthplace Lexington (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Retired

11. Industry or business Manufacturer

FATHER
12. Name George C. Bain
13. Birthplace Lexington (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Catherine Judith Martin
15. Birthplace Lexington (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant's own signature Patterson Bain Jr.
(b) Address 5331 Delmar Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-40 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine, Cem.

18. (a) Signature of funeral director Wagoner Und. Co.
(b) Address 3621 Olive St., St. Louis

19. (a) JAN 22 1940 (Date received by local registrar) (b) [illegible] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1940 hour 10 minute a. M.

21. I hereby certify that I attended the deceased from 1925, to Jan 21, 1940
that I last saw him alive on Jan 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneum — Duration 4-5 days

Due to general arteriosclerosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Samuel P. Grant (M. D. or other) M.D.
Address 114 N. Taylor Ave Date signed 1/22/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 3621 Olive St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.