

No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6796

FILED FEB 24 1947

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1660**

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST LOUIS CHILDRENS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Kenny Lane Paul
3. (b) If veteran, _____ name war _____
3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 7 1946
(Month) (Day) (Year)

8. AGE: Years 0 Months 3 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace IRONTON Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name OLIN PAUL
13. Birthplace DONIPHAN Mo
(City, town, or county) (State or foreign country)
14. Maiden name SELMA MCKINNEY
15. Birthplace PONDER Mo
(City, town, or county) (State or foreign country)

16. (a) Informant MR OLIN PAUL
(b) Address DONIPHAN, Mo

17. (a) BURIAL (b) Date thereof 2-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DONIPHAN, Mo

18. (a) Signature of funeral director ROWLAND SERVICE
(b) Address 4355 WASHINGTON, AV.

19. (a) FEB 18 1947 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County RIPLEY 91
(c) City or town DONIPHAN
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 15
year 1947 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from 2-13-47, 19____, to 2-15, 1947.
that I last saw him alive on 2-15, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Hepatitis
Due to _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. J. Blotter (M. D. or other) _____
Address 170 So. Kingshighway Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

Ronald Yahrke

Licensed Embalmer No..... *3917*.....

P. O. Address..... *4355 Washington Ave*.....

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 this body is not embalmed, fact should be so stated above.