

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED SEP 23 1948  
Registration District No. 289

Primary Registration District No. 3043

Registrar's No. 298

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Residence 1103 Park Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1103 Park Avenue  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country: .....

3. (a) PRINT FULL NAME Albert Enos Cain  
3. (b) If veteran, name war: ..... 3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month September day 15  
year 1948 hour 6 minute 15 P. M.

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: August 5, 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 28, 1948 to September 15, 1948  
that I last saw him alive on Sept 14, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarction & hepatic  
Due to: .....  
Due to: .....

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>1</u>	<u>10</u>	..... hr. .... min.

Other conditions: Myocardial infarction & hepatic  
(Include pregnancy within 3 months of death)  
PHYSICIAN: .....

9. Birthplace: Macon County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business: .....

12. Name: Henry Waling Cain

13. Birthplace: Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name: Lovinia Johnson

15. Birthplace: Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant: Miss Gertrude Cain  
(b) Address: 1103 Park Hannibal Mo.

17. (a) Burial (b) Date thereof: 9/18/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Salem Cemetery

18. (a) Signature of funeral director: W. C. M. Puckler  
(b) Address: 902 Broadway Hannibal Mo

19. (a) 9-17-48 (b) W. C. M. Puckler  
(Date received local registrar) (Registrar's signature)

Major findings: 9/15/48  
Of operations: .....  
Of autopsy: .....

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)

Did injury occur in or about home, on farm, in industrial place, in public place? .....  
While at work? ..... (Specify type of place)  
(c) Means of injury: .....  
23. Signature: [Signature] (M. D. or other) .....  
Address: [Address] Date signed: 9/15/48

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

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 \_\_\_\_\_

*H. Crawford Smith*

Licensed Embalmer No. #11,3814

P. O. Address Hannibal Missouri

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.