

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37077

FILED OCT 29 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9960

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>CHRISTIAN Hosp</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u> <u>2089</u> d. STREET ADDRESS (If rural, give location) <u>9154 LONGRIDGE DR</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>THEODORE</u> b. (Middle) _____ c. (Last) <u>CAINE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-18-53</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7-27-1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HARDWARE Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>BUFFALO, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Geo CAINE</u>		13b. MOTHER'S MAIDEN NAME <u>SUSANNA R COLLINSON</u>		14. NAME OF HUSBAND OR WIFE <u>CLARA BELLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES SPANISH AMER</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Helma Kelly</u>				ADDRESS <u>9154 Longridge</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular accident Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive arteriosclerosis</u> <u>of the brain</u> DUE TO (c) <u>Cerebral infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 years</u> <u>15 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHOLE AT WORK <input type="checkbox"/> NOT WHOLE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5810</u>				
22. I hereby certify that I attended the deceased from <u>10/16, 1953</u> , to <u>10/18, 1953</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Eugene G. Mallick M.D.</u>		23b. ADDRESS <u>P.O. 7503, J. J. ...</u>		23c. DATE SIGNED <u>10/19/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-21-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>		
DATE REC'D BY LOCAL REG. <u>OCT 19 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. K. ...</u>			ADDRESS <u>27079 Grand</u>

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

VE Morris

Licensed Embalmer No. *3360*

P. O. Address *St Louis, Mo*

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

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