

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6004**  
Registrar's No. **1531**

FILED MAR 4 1954  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Johns Hospital.</b>		e. STREET ADDRESS (If rural, give location) <b>4333 Farlin Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Eliza</b>	b. (Middle) <b>Maggie</b>	c. (Last) <b>Cain</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 14, 1954.</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Feb. 7, 1879.</b>	9. AGE (In years last birthday) <b>75.</b>	10 UNDER 1 YEAR Months Days	10 UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Phelps County, Missouri.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Samuel Riley</b>	13b. MOTHER'S MAIDEN NAME <b>Harriet Riley</b>	14. NAME OF HUSBAND OR WIFE <b>David Lue Cain.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Pearl Gutschlag,</b>	ADDRESS <b>4333 Farlin Ave.</b>
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Inter capillary Glomerulonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Diabetes Mellitus</b>		
	DUE TO (b) _____ DUE TO (c) _____ <b>Generalized Arteriosclerosis</b> <b>Cerebral Thrombosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>5 years</b> <b>2 years</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <b>260x</b>

22. I hereby certify that I attended the deceased from **April 24, 1950,** to **Feb. 14, 1954,** that I last saw the deceased alive on **Feb. 14, 1954,** and that death occurred at **12:30 p.m.,** from the causes and on the date stated above.

23a. SIGNATURE <b>Frank J. Mangum MD</b>	(Degree or title)	23b. ADDRESS <b>1695 S. Brentwood</b>	23c. DATE SIGNED <b>2-15-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-18-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hills Garden</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 16 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington.</b>
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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.....  
Signature of Student Embalmer

Signed.....  
*John J. Hamie*

Licensed Embalmer No. *410*

P. O. Address *St. Louis*

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.