

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037990
STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10188

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5765 Pershing, Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
38 3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Enroute City Hospital DOA</u>		Length of stay in 1b <u>2059</u>			
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>Lloyd</u> Last <u>McGinnis</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1905</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor St. Louis Art Museum</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Museum</u>		11. BIRTHPLACE (City and state or country) <u>Sigel-Shelby County, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>James Ludwell McGinnis</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Elizabeth Tolch</u>	
14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>	
17. INFORMANT <u>Mrs. Russell Walden, Matton, Illinois.</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis acute ventricular fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <u>5:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		and last saw ^{her} him alive on <u>10/3/58</u>			
21a. SIGNATURE <u>Robert Rame</u> (Degree or title) <u>M.D.</u>		21b. ADDRESS <u>3720 Washington</u>		21c. DATE SIGNED <u>10/24/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-23-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Neoga Memorial Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Neoga, Illinois.</u>		23e. STATE <u>Illinois.</u>			
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington, Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 24 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *H. D.*

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.