

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19371

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**

City **St. Louis** (No. **1939**, Wyoming St.)

File No.

Registered No. **5319**

St. Ward)

2. FULL NAME

(a) Residence. No. **1939 Wyoming** St., **24** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** **4. COLOR OR RACE** **White** **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Late Michael Katesky**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 28, 1850**

7. AGE YEARS MONTHS DAYS **80 4 7** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housemaid**
(b) General nature of industry, business, or establishment in which employed (or employer) **at home**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Louis Ford**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Richmond**
(STATE OR COUNTRY) **Virginia**

12. MAIDEN NAME OF MOTHER **Susan Mahanes**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Valley Forge**
(STATE OR COUNTRY) **Pennsylvania**

14. INFORMANT **Mrs. D. P. Schofield**
(Address) **1939 Wyoming**

15. FILED **1937** **REGISTERED**

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-5 1937**

17. HEREBY CERTIFY, That I attended deceased from **Dec 15 1919**, to **May 4 1931**, that I last saw him alive on **May 4 1931**, and that death occurred, on the date stated above, at **9:30 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia
59
131
936 (duration) yrs. mos. ds.
Coronary Myocarditis
(SECONDARY) **Arteriosclerosis**
Bright's disease (duration) **12** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF **1**

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Dr. Althaus** M. D.
5/5 1937 (Address) **3248 Lafayette Ave**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bellefontaine Cem** **5-7 1937**
DATE OF BURIAL

20. UNDERTAKER **Wiegand & Co. So. Highway**
ADDRESS **4228**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

3

2

1

4