DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16141

FILED MAY 8 1940

Registration District No. 87 — Primary Registration District No. 117 — Registrar's No. 792

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.

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: V
103 W Cedar
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 82 yrs (Specify whether years, months or days) 160

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 103 Cedar Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? —— years.

3. (a) PRINT FULL NAME KATHARINE Robison AVERY
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Female
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 Aug (Month) 19 (Day) 1856 (Year)

8. AGE: Years 83 | Months 8 | Days 2 | If less than one day — hr. — min.

9. Birthplace St Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation At Home
11. Industry or business —

MOTHER
12. Name Edward M Avery
13. Birthplace West Port (City, town, or county) Conn (State or foreign country)

FATHER
14. Maiden name Sarah Robison
15. Birthplace Wooster (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Chas. M. Avery
(b) Address Webster Groves
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 23 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director Parker Undertaking Co
(b) Address Webster Groves Mo
19. (a) APR 25 1940 (Date received by Registrar) (b) C. R. Mayes M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1940 hour 12 minute 5 A.M.

21. I hereby certify that I attended the deceased from July, 1939, to April 21, 1940, that I last saw her alive on April 21, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: (a) Chronic Myocarditis	1 year
Due to: (b) ~~Pneumonia~~	~~1 day~~
Due to: (c) Generalized Arteriosclerosis	20 years
Due to:	
Other conditions: Senility, Carcinoma uteri (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically

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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature David M. Skilling Jr. (M. D. or other)
Address 4500 Olive Street St Louis Date signed 4/25/40

(Licensed Embalmer's Statement on Reverse Side)

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 Orrin B Lang

Licensed Embalmer No. 1556

P. O. Address Webster Groves

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

If this body is not embalmed, above space should be left blank.