

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **331486**

**OCT 10 1940**  
Registration District No. **784**

Primary Registration District No. **111**

Registrar's No. **1757**

**1. PLACE OF DEATH:**  
(a) County **ST. LOUIS**  
(b) City or town **Richmond Heights**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**ST. MARY'S HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1**  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **KATHERINE G. HIRSHMAN**  
**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** **WIDOW**  
**6. (b) Name of husband or wife** **GEORGE E. HIRSHMAN** **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **SEPT 3 1957**  
(Month) (Day) (Year)

**8. AGE:** Years **83** Months **0** Days **11** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** **PITTSBURG** **INDIANA**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **HOUSEWIFE**

**11. Industry or business** **AT HOME**

**12. Name** **JEREMIAH J. McGRATH**

**18. Birthplace** **IRELAND**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **KATHERINE SULLIVAN**

**15. Birthplace** **IRELAND**  
(City, town, or county) (State or foreign country)

**18. (a) Informant's own signature** *Mrs. J. Woodlock*

**(b) Address** **3663 McREE AVE.**

**17. (a) BURIAL** (b) Date thereof **SEPT. 17 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **CALVARY CEMETERY**

**18. (a) Signature of funeral director** **FEETZ BROS.**

**(b) Address** **3029 LAFAYETTE AVE.**

**19. (a) SEP 16 1940** (b) *K. Meyer*  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **MISSOURI** (b) County \_\_\_\_\_  
(c) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3663 McREE AVE.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **SEPT.** day **14th.**  
year **1940** hour **9** minute **15** P. M.

**21. I hereby certify that I attended the deceased from** **May 27<sup>th</sup>**, 19**40** to **Sept 14<sup>th</sup>**, 19**40**  
that I last saw **her** alive on **Sept 14<sup>th</sup>**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertension**  
**Myocardial Disease**

Due to \_\_\_\_\_ **4 months**

Due to \_\_\_\_\_

Other conditions **Fracture Head of Femur** **Left** **1 month**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy **none.**

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

**23. Signature** **August J. Nechman** M. D. or other \_\_\_\_\_

Address **4666 Maryland** Date signed **9/16/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 1-1935

144A  
AW

1-3  
8

1-3  
8

1-3  
8

**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 Paul J. Swans

Licensed Embalmer No. 2245

P. O. Address ST. LOUIS, MO.

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33148  
Registrar's No. 1757-

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County St. Louis's Hts.  
(b) City or town Rich. Hts.  
(c) Name of hospital or institution: St. Marys Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Katherine C. Hochman  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Sept day 14-40  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death Myocardial disease

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other condition Fract. head of femur  
(Include pregnancy within 3 months of death) 1 month -

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 186 a/b

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) 9-16-40 (b) TR Hochman mod pd  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Aug 25<sup>E</sup> 1940  
(c) Where did injury occur? St. Louis Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home (Specify type of place)  
While at work? No (c) Means of injury Fell out of bed  
23. Signature August G. Hochman (or other) M.D.  
Address 465 Maryland ave Date signed 11/1/40

SUPPLEMENTARY

