

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33902**
Registrar's No. **8599**

Register District No. **7911** Primary Registration District No. **1003**

PLACE OF DEATH:

(a) County **St. Louis.**
(b) City or town **St. Louis.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **60 Years.** (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **Katherine Byrne.**

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 **Dont Know 1858**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 Dont Know hr. min.

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

10. Usual occupation **At Home.**

11. Industry or business _____

12. Name **Unknown.**

13. Birthplace **Ireland.**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown.**

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

16. (a) Informant **Mr. E. J. H. Bennett.**

(b) Address **226 Rosemont.**

17. (a) **Burial** (b) Date thereof **10-19-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd.**

19. (a) **OCT 18 1940** (b) **J. F. Bickel**
(Date of occurrence) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis, Mo.** (If outside city or town limits, write "RURAL")
(d) Street No. **3864 Page Blvd.** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **17**
year **1940** hour **6** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Aug 1**, 19**40**, to **Oct 17**, 19**40**.
that I last saw her alive on **Oct 16, 1940**, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic myeloid leukemia

Due to **Heart failure**

Due to _____

Other conditions _____
(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? _____

While at work? _____ (Specify type of place)
(b) Means of injury **1**

23. Signature **W. V. White** (M. D. or other) _____

Address **2803 N. Kingshighway** Date signed **10-17-40**

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Linden

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.