

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **6249**

Registration District No. **318** Primary Registration District No. **1603**

1. 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: **City Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution **1 Day**
In this community **8 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2112 Cherokee St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Katherine Horlamus**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **11**
year **1944** hour **11** minute **20 P.M.**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife **John** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 26 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	79	4	16	_____ hr. _____ min.

Immediate cause of death **Acute Cholecystitis with Inflammatory Obstruction of Cystic and Common Bile Ducts**
Due to **Platyphoritis about Gall Bladder - Generalized**
Due to **Arteriosclerosis**
Other conditions **arteriosclerosis**
(Include pregnancy within 3 months of death)

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Home**

Major findings: Of operations **1/26**
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name **Benjamin**
13. Birthplace **Unknown**
14. Maiden name **Marshall**
15. Birthplace **Holland**

16. (a) Informant **Bessie Weber**
(b) Address **3920a Nebraska Ave.**

17. (a) **Cremation** (b) Date thereof **July 14, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Missouri Crematory**

18. (a) Signature of funeral director **Thacker Helderle**
(b) Address **3634 Gravois Ave.**

19. (a) **JUL 14 1944** (Date received local registrar)
J. S. Bredek (Registrar's signature)

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? _____

23. Signature **Thacker Helderle** (Specify type of place) (M. D. or other)
Address **3634 Gravois Ave.** Date signed **7/14/44**

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

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..... *Robert C. Wheeler*
Licensed Embalmer No. *2178*
P. O. Address *H. Harris MD*

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, fact should be so stated above.