

V. S. No. 2
FORM-8-43
Rev. 5-17-39
K37823

31803

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 217

Primary Registration District No. 6076

Registrar's No. 1876

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: O'SULLIVAN HOME St. Anns Lane Normandy
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks
(Specify whether years, months or days)

In this community 36 Years in St. Louis
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 800

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3467 Montana
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME KATHERINE ORTINAU

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased June 29 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>2</u>	<u>8</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business Housewife

12. Name Anthony Kussin

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

14. Maiden name Unknown

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

16. (a) Informant Sussie Frohmann

(b) Address 3467 Montana St

17. (a) Burial (b) Date thereof Sept 9/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul Cem

18. (a) Signature of funeral director Thorpe & Son

(b) Address 2906 Gravois Ave.

19. (a) SEP 9 - 1944 E. L. McLawson, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6
year 1944 hour 3 55 P.M. minute 00

21. I hereby certify that I attended the deceased from March 1 1944 to Sept 6 1944

that I last saw her alive on Sept 6 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia long.

Due to Senility

Duration 1 yr.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 1626

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?

(e) Means of injury

23. Signature E. L. McLawson (M. D. certifier)

Address 7924 S. Grand Date signed 9/8/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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...

David Lee Fossan

Licensed Embalmer No. *4242*

P. O. Address *2906 Grannis*

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.