

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

36524

State File No.

FILED NOV 30 1944

9749

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
De Paul Hospital
 (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)

3. (a) PRINT FULL NAME Katherine Marie Walsh

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 0
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased Sept. 30 1944
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>1</u>	<u>16</u>	hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name Unknown
 13. Birthplace.....
 (City, town, or county) (State or foreign country)
 14. Maiden name Allene Walsh
 15. Birthplace.....
 (City, town, or county) (State or foreign country)

16. (a) Informant Childrens Home Society(b) Address 4415 Margaretta ve.17. (a) Burial (b) Date thereof 11-17-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lake Charles18. (a) Signature of funeral director Drehmann-Harral(b) Address 1905 Union Blvd.19. (a) NOV 17 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4415 Margaretta Ave.
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16
year 1944 hour 2 minute P. M.21. I hereby certify that I attended the deceased from Nov 1 - 1944
19 Nov 16 19 44
that I last saw her alive on Nov 16 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death

Enter-enteritis, 2 1/2 days
 Due to Probably of virus type
 Due to meningococci, of a few hours.

Other conditions.
(Include pregnancy within 3 months of death)Major findings:
Of operations.....Of autopsy yes

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? Yes (Specify type of injury) (a) Means of injury ...
 23. Signature J. F. Bredeck (M. D. or other)
 Address 3730 Washington Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. LeRoy Robertson
Beaumont Bldg.
8:30 to 11

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 *Truce Costello*
No Embalming Licensed Embalmer No.
P. O. Address.....

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.