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5-17-39  
P-I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CONSUL

THE STATE BOARD OF HEALTH OF MISSOURI

4353

**FILED MAR 9 1945**  
Registration District No. \_\_\_\_\_

**318** Primary Registration District No. **1003**

State File No. \_\_\_\_\_  
Registrar's No. **1765**

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
2725 N Taylor Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community 4 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County \_\_\_\_\_

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

(d) Street No. 2725 N Taylor Ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Katie Herring

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Seperated 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 12, 1904  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19  
year 1945 hour 8 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Dec 1944 to Feb 19 1945  
that I last saw her alive on Feb 19 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 40 Months 10 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Haywood County Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

Immediate cause of death ascent, chronic Myo-Carditis

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

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

Other conditions 9/3  
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name John Ragland

13. Birthplace Haywood Co, Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Dathoula Miller

15. Birthplace Haywood Co, Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant John Ragland  
(b) Address 2725 N Taylor Ave.

17. (a) Burial (b) Date thereof 2-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Ellis Fun, Home  
(b) Address 2820 Stoddard St

19. (a) FEB 23 1945 J. F. Bredeek  
(Date received local Registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury 0

23. Signature J. F. Bredeek (M. D. or other) \_\_\_\_\_  
Address 2743 Franklin Date signed 2/23/45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

J. E. Hurt

**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 L. Boylan

....., Registered Apprentice No. Imp

working under my personal supervision.

Signed Louise Boylan

Licensed Embalmer No. 2946

P. O. Address St. Louis 9MO

**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.**