

FILED MAY 12 1945

318

Registration District No.

1003

State File No.

Registrar's No.

3787

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

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 3 mos 18 days  
(Specify whether  
In this community 3 mos 18 days  
years, months or days)

3. (a) PRINT FULL NAME CATHERINE HATZ

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, 2 divorced WIDOWER

6. (b) Name of husband or wife JOSEPH 6. (c) Age of husband or wife if alive          years

7. Birth date of deceased JUNE 19 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 10 7 hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant MISS E. HATZ

(b) Address EDWARDSVILLE ILL

17. (a) REMOVAL (b) Date thereof 4-28-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST MARYS Cem. EDWARDSVILLE

18. (a) Signature of funeral director STRAUBE FUNERAL HOME

(b) Address EDWARDSVILLE ILL

19. (a) APR 29 1945 (b) J. F. Meser  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILL (b) County MADISON  
(c) City or town EDWARDSVILLE  
(If outside city or town limits, write "RURAL") NR  
(d) Street No.          (If rural, give location)  
(e) Citizen of foreign country?          (Yes or No)  
If yes, name country         

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 26 year 1945 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan 7, 1945 to April 26, 1945  
that I last saw him or alive on April 26, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Occlusion Duration 3 hours

Due to Also had metastatic carcinoma from old breast amputation  
Duration about 7 yrs ago

Other conditions 50  
(Include pregnancy within 3 months of death)

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) Means of injury         

23. Signature J. F. Meser (M. D. or other) MD  
Address          Date signed 4/27/45

**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

*R. E. Campbell*

Licensed Embalmer No. *3881*

P. O. Address *St. Louis Mo*

**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.**