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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

Registration District No. 0

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21245

Primary Registration District No. 6076

Registrar's No. 1219

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3670 Manola Ave.
(If not in hospital or institution, write street number or location)

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

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis

(c) City or town: Pine Lawn
(If outside city or town limits, write "RURAL")

(d) Street No.: 3670 Manola Ave.
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: Katherine Louise Hartung

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: Widowed

6. (b) Name of husband or wife: Frank Hartung

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

7. Birth date of deceased: Feb. (Month) 23 (Day) 1860 (Year)

8. AGE: Years 85 | Months 3 | Days 4 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business ____

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: John F. Schueremann

(b) Address: 3670 Manola Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-30-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Bellefontaine

18. (a) Signature of funeral director: Drehmann-Harral

(b) Address: 1905 Union Blvd.

19. (a) MAY 28 1945 (Date received local registrar) E. B. McGauran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1945 hour 6 minute 10 P.M.

21. I hereby certify that I attended the deceased from January 3, 1940 to May 27, 1945. 19____; that I last saw her alive on May 25, 1945. 19____; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic myocarditis,	
chronic interstitial nephritis,	5
and malignant hypertension.	years.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: [signature] M.D. (M. D. or other)

Address: 320 Metropolitan Bldg. Date signed: 5/28/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. D.C.Raines
Metro-- Bldg.
9-11 & 1-3

(Je. 5101)

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 Warren A. Carver

Licensed Embalmer No. 3534

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.