

FILED JAN 31 1946
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(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:
CITY ISOLATION HOSPITAL, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3/17/43 to
(Specify whether)

In this community _____ I/9/1946.
years, months or days

3. (a) PRINT FULL NAME KATE BANKS.

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 SINGLE

6. (b) Name of husband or wife _____

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

7. Birth date of deceased DECEMBER 29 - 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>-</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace ST. LOUIS, MO. 11
(City, town, or county) (State or foreign country)

10. Usual occupation STENOGRAPHER.

11. Industry or business _____

MOTHER FATHER

12. Name UNKNOWN. 4

13. Birthplace IRELAND. 4
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN.

15. Birthplace IRELAND. 4
(City, town, or county) (State or foreign country)

16. (a) Informant CITY INFIRMARY.

(b) Address 5800 ARSENAL ST.

17. (a) BURIAL JAN 12 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schuur

(b) Address 3125 Lafayette Ave.

19. (a) JAN 11 1946 H. Breda
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI. (b) County DOU

(c) City or town ST. LOUIS, MO. 73/7
(If outside city or town limits, write "RURAL")

(d) Street No. 2102 LAFAYETTE AVE. 9
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 9
year 1946 hour 11:55 minute _____ P. M.

21. I hereby certify that I attended the deceased from 9/77
10/19/45, 1945 to Jan 9, 1946
that I last saw her alive on Jan 9, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to base

Due to 107

Other conditions Generalized arterio-
sclerosis + senility

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? _____

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature John E. Keller (1) M.D.
Address 5800 Arsenal Date signed 1/14/46

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 Joe B Vollmer
Licensed Embalmer No. 4014
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.