

FILED JAN 25 1946

1009

Registration District No. 318

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
City Sanitarium 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months
(Specify whether Life) In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL.") 1417

(d) Street No. 4541 Varrelman (If rural, give location) 9

(e) Citizen of foreign country? no (Yes or No) 10

If yes, name country

3. (a) PRINT FULL NAME Kathrine Mary Sharp

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 6
year 1946 hour 10 minute 358 M.

21. I hereby certify that I attended the deceased from
....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

4. Sex F / race W

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas D 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased 12 (Month) 1 (Day) 1870 (Year)

Immediate cause of death Fracture of right femur
halverson disease
when she fell to the floor
at City Sanitarium on
Dec 17, 1945 - exact time
unknown

Due to.....

Due to.....

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

186
38

8. AGE: Years Months Days If less than one day

75 1 5 hr. min.

9. Birthplace St. Louis Missouri-0
(City, town, or county) (State or foreign country)

Nil

10. Usual occupation.....

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name Wm. Powers

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Kathryn Mort

(b) Address 4541 Varrelman, St. Louis, Mo

17. (a) Burial (b) Date thereof 1-10-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Dec 17 1945 000

(c) Where did injury occur at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, industrial place, in public place?
Cemetery City Sanitarium
(Specify type of place)

While at work at home (e) Means of injury fall

23. Signature J. F. Brediek (M. D. or other) 1/8/46
Address 249 E 10th Date signed 1/8/46

(c) Place of burial or cremation Old St. Peter & Paul

C. HOFFMEISTER COLONIAL MORTUARY

18. (a) Signature of funeral director

(b) Address 6464 Chippewa, St. Louis, Mo

19. (a) JAN 9 1946 (Date received local registrar) J. F. Brediek (Registrar's signature)

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

3110

*For: [redacted]
City [redacted]
Business Office*

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 *Harry J. Skumaker*
Licensed Embalmer No. *2679*
P. O. Address *78148 Broadway*

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.