DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14981

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3165

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:
4500 Arsenal
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 68 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 1617
(If outside city or town limits, write "RURAL")

(d) Street No. 4500 Arsenal 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Catherine McKenzie

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife James McKenzie

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

7. Birth date of deceased December (Month) 7 (Day) 1877 (Year)

8. AGE: Years 68 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name William Brutton
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Anna Berney
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Ann McKenzie Ann McKenzie
(b) Address 4500 Arsenal

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bensiek-Niehaus
(b) Address 1431 Union Blvd

19. (a) APR 5 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1946 hour 7 15 minute P. M.

21. I hereby certify that I attended the deceased from
Jan, 1943, to April 3, 1946
that I last saw her alive on April 3, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of lung metastatic	3 mo
Due to: Carcinoma of breast	2 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITION SUPPLEMENTARY INFORMATION RECEIVED
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 Anthony B. Day (M. D. ~~or other~~)
Address 3720 Washington Blvd Date signed 4-5-46

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.

2B
45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3168

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:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

3. (a) PRINT FULL NAME Catherine McKenzie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 7 (Day) 8 (Year)

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

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 3
year 1946 hour minute 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.

Immediate cause of death Metastatic carcinoma, primary breast

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 50
Of autopsy

Duration

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 Anthony B. Day (M. D. or other)
Address 3720 Washington Blvd Date signed 4-27-46

SUPPLEMENTARY

1388

14981