

FILED APR 17 1946

1003

Registrar's No. 3147

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos
(Specify whether years, months or days)

In this community 40 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 23

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

(d) Street No. 1715 E. Magnolia
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME KATHERINE MENKE

MEDICAL CERTIFICATION

3. (b) If veteran, name war no

3. (c) Social Security No. no

20. DATE OF DEATH: Month April day 3rd year 1946 hour 3:40 minute A M.

4. Sex Female 5. Color or race white

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

6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased: Jan 30 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/4/46 to 4/3/46 19, and that death occurred on the date and hour stated above.

er 4/3/46 19

that I last saw her alive on 4/3/46 19

8. AGE: Years 76 Months 2 Days 3 If less than one day hr. min.

Immediate cause of death: Carcinoma of Bladder
URINARY

Due to 52

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

Other conditions: Senescent arteriosclerosis
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Papillary Carcinoma of Bladder

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business self

12. Name Adam Kuettermann

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

14. Maiden name Marlene Schwab

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

16. (a) Informant Lillie B. Popis

17. (a) Address 1615 1/2 Popis

17. (a) Cremation (b) Date thereof 4/5/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Voluntary Crematory

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 D

23. Signature E. N. Cason Address 1515 Lafayette Date signed 4/8/46
(Other)

MOTHER FATHER

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

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.....

John Agoropki

Licensed Embalmer No. *3398*.....

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.