

No. 2
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5-17-39
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DEPARTMENT OF HEALTH
BUREAU OF THE CENTRAL
FILED NOV 25 1946
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39181**
Registrar's No. **9459**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hosp. O
(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

3. (a) PRINT FULL NAME Katherine Vieh
3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife William Vieh 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 18 1890
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____
12. Name Patrick Mackle #
13. Birthplace Ireland #
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Donnelly #
15. Birthplace Ireland #
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Lawrence
(b) Address 6311 S. Rosebury Av.

17. (a) Burial (b) Date thereof 11-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Watt Bro. Co. Inc.
(b) Address 2929 S. Jefferson Av.

19. (a) NOV 5 1946 (b) J. F. Prudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis 13 #
(If outside city or town limits, write "RURAL") #
(d) Street No. City Infirmary #
(If rural, give location) #
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 3
year 1946 hour 1 minute 19 p. 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 Labor Pneumonia
prolonged right leg when
she fell to the floor while
getting out of bed at the
Due to _____
Due to City Infirmary on Oct 26 1946
about 7:00 P.M.

Other conditions _____
(Include pregnancy within 3 months of death) 186
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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) Accident 001
(b) Date of occurrence Oct 26 1946
(c) Where did injury occur? at home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
City Infirmary
While at work? _____ (Specify type of place)
Means of injury fall
23. Signature Alfred J. Perry (M. D. or other) #
Address 1144 1/2 E. 11th Date signed 11/4/46

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

D. M. Davis

Licensed Embalmer No. *3741*

P. O. Address.....

2929 So. Jefferson Ave

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.