

Registration District No. **318**

Primary Registration District No. _____

State File No. _____

Registrar's No. **10532**

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:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 months
(Specify whether)
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
 (d) Street No. 15 Orchard Lane
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Catherine B. Comfort

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced DIVORCED
 6. (b) Name of husband or wife Benjamin Comfort
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 19 1894
(Month) (Day) (Year)

8. AGE: Years 52 Months 10 Days 19
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER
 { 12. Name Michael J. Gibbons
 { 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 { 14. Maiden name Lyden
 { 15. Birthplace Wisc.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Mills
 (b) Address 7024 Glades Ave. St. Louis Mo
 17. (a) Burial (b) Date thereof 12/11/46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Meyer-Pfizinger Funeral Home
 (b) Address 1222 S. Kirkwood Rd. Kirkwood 22, Mo.
 19. (a) DEC 9 1946 (b) J. J. [Signature]
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 8
 year 1946 hour 6 minute 40 A. M.
 21. I hereby certify that I attended the deceased from September 9th, 1946, to Dec 8th, 1946.
 that I last saw h. ER alive on Dec 7th, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of cervix uteri
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 9/20/46 - 10/1/46 Radium Implant
 Of operations _____
 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? _____

While at work? 0 (Specify type of place) _____
 (a) Means of injury _____
 23. Signature John B. O'Neil (M. D. or other) _____
 Address 1222 Missouri Theater Bldg signed 12/9/46

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

APR 22 1947

JUL 8 1947

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

William H. Oettinger

Licensed Embalmer No.

40316

P. O. Address

*12 Winnetka Lane
Glen Dale, 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.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10582

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 years, months or days)

3. (a) PRINT FULL NAME

Catherine B. Compton

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

7. Birth date of deceased: Jan 19 (Month) 19 (Day) 19 (Year)

8. AGE: Years 52 Months 10 Days 10 (if less than one day)
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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

{ 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) 12-9-1946 (Date received local registrar) (b) J. F. Bruck (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

422607