

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAR 14 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2376

Registration District No. _____ Primary Registration District No. 1003

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1113 Aubert Ave.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) _____
 If yes, name country _____

3. (a) PRINT FULL NAME IRENE CATHRELL
 3. (b) If veteran, name war --
 3. (c) Social Security No. --

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th
 year 1947 hour 12 minute 20 P.M.

4. Sex Female B. Color or race C
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Geo. M. Cathrell years _____
 6. (c) Age of husband or wife if _____ years _____
 7. Birth date of deceased November 5, 1887
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day
59 4 0 _____ hr. _____ min.

Immediate cause of death _____

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

Due to Coronary Occlusion
Ischemia

10. Usual occupation Practical nurse

Due to _____

11. Industry or business Ferrier Harris Home for

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

12. Name Unavailable

Major findings: _____
 Of operations _____
 Of autopsy _____

13. Birthplace Unavailable

14. Maiden name Eliza Gasway

15. Birthplace Unavailable

16. (a) Informant Irene Cathrell

(b) Address 9053 S. Yale, Chicago, Ill

17. (a) Burial (b) Date thereof 3-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) MAR 8 1947 (Registrar's signature) _____
(Date received local registrar)

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 _____ (M.D. or other) _____
 Address 1300 Clark Ave. Date signed _____

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

MOTHER FATHER

18

STATEMENT BY LICENSED EMBALMER

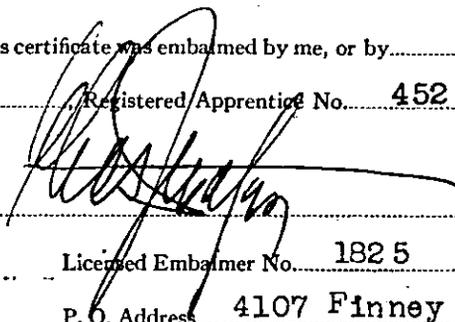
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John K. Cunningham

Registered Apprentice No. 452

working under my personal supervision.

Signed.....



Licensed Embalmer No. 1825

P. O. Address 4107 Finney 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.