

FILED JUN 5 1947
#26404
318

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
 (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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **25 days**
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Good**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **310a Souland Street**
23 Memorial (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **KATE VAN DYKE**
 3. (b) If veteran, name war.....
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27th**
 year **1947** hour **3:40** minute **A** M.
 21. I hereby certify that I attended the deceased from **5/4/47**
 19....., to **May 27th** 19 **47**
 that I last saw her alive on **May 27th** 19 **47**
 and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **John W.** 6. (c) Age of husband or wife if alive **.....** years
 7. Birth date of deceased **July 7th, 1879**
(Month) (Day) (Year)

Immediate cause of death.....
Anoxemia
 Due to **Pulmonary Fibrosis**
 Due to **Bronchial Asthma**
 Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	67	10	20hr.min.

9. Birthplace **De Sota, Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **home**

Major findings:
 Of operations.....
 Of autopsy.....
1/14

11. Industry or business.....
 12. Name **Dilly L. Huskey**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Eoff**
 15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Anderson**
 (b) Address **2816 So. 18th, St. Louis, Mo.**
 17. (a) **burial** (b) Date thereof **May 31, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **New St. Marcus Cemetery**

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 **Joe H. Anderson** **5/27/47** M.D.
 Address **1515 Lafayette** Date signed.....

18. (a) Signature of funeral director **Hacker, Helderich & Co.**
 (b) Address **3634 Gravois St. St. Louis, Mo.**
 19. (a) **MAY 28 1947** (b) **J. F. Brodeck**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration **1 1/2 days**
 ?
15 yrs.
 PHYSICIAN
 Underline the cause of which death should be charged statistically.

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..... *Robert Wheeler*

Licensed Embalmer No. *2128*

P. O. Address *St Louis 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.