

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39977**
Registrar's No. **11756**

FILED DEC 15 1947

Registration District No. **318**

Primary Registration District No. **1003**

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

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:
2844 LEMP (REAR)
(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 MICKA**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **FEMALE** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **JULY 9 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

73 4 25 hr. min.

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

10. Usual occupation **AT HOME**

11. Industry or business.....

12. Name **VALENTINE MICKA**

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

14. Maiden name **CATHERINE PORT**

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

16. (a) Informant **MRS. BRINKER**

(b) Address **2844 LEMP**

17. (a) **BURIAL** (b) Date thereof **DEC. 8, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **S. S. PETER + PAUL CEM.**

18. (a) Signature of funeral director **Thomas Adin + son**

(b) Address **2906 FRAYOLS**

19. (a) **DEC 5 - 1947** (b) **J. A. Beedeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **KOD**

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **2844 LEMP (REAR)**
24 (If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **4**
year **1947** hour **12** minute **45** P.M.

21. I hereby certify that I attended the deceased from **11-1-47** to **12-5-47**
that I last saw her alive on **12-2-47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of left breast**

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autops:.....

23. 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?..... (Specify type of place)

Means of injury.....

23. Signature **Oley Jones** (M. D. or other) **MD**
Address **3616 S. Ruffin** Date signed **12-6-47**

Duration **5 yrs**

PHYSICIAN

Underline the cause of which death should be charged statistically.

3612 J. P. Brown
Nov. 1 to 6 p.m. Steyer House.
La 5626

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..... *Samuel C. Hill*

Licensed Embalmer No..... *4347*

P. O. Address..... *2906 Du Bois*

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.