S. No. 2
M—1/47
r. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40484

FILED DEC 8 1947

Registration District No. 1947

Primary Registration District No. 6076

Registrar's No. 2477

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 431 W. Rippa Ave.
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3517 Taft Ave. 9
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 1
If yes, name country .....

3. (a) PRINT FULL NAME Kate Breen
3. (b) If veteran, name war --
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife Patrick
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased Sept. (Month) 5 (Day) 1872 (Year)

8. AGE: Years 75 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Home
11. Industry or business .....

FATHER
12. Name Jacob Kaebel
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Lillie Blum
(b) Address 431 W. Rippa, Lemay, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/47 (Month) (Day) (Year)
(c) Place: burial or cremation O. St. Marcus
18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave.
19. (a) 12-2-1947 (Date received local registrar) (b) Cecil A. Shaw MD (Registrar's signature) MSH

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30
year 1947 hour 8 minute 30A. M.

21. I hereby certify that I attended the deceased from 11/15, 1947, to 11/30, 1947
that I last saw her alive on 11/30/47, 19....
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Ac Dilation of Heart	2 hrs
Due to chronic vascular heart disease	yrs
Due to	
Other conditions Cholecystitis (Include pregnancy within 3 months of death)	yrs

Major findings:
Of operations 93d
Of autopsy

PHYSICIAN
Underline the cause of 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 0

23. Signature Louis Creulina (M. D. or other)
Address 752 Lemay Ferry Rd Date signed 12/1/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.