

National Office of Vital Statistics
FILED JUL 14 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21710**

Registration District No. **577**

Primary Registration District No. **6076**

Registrar's No. **1669**

1. PLACE OF DEATH:
 (a) County **ST. LOUIS**
 (b) City or town **NORMANDY**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **MOTHER OF GOOD COUNSEL HOME**
 (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 **Mo.** (b) County **ST. LOUIS 96**
 (c) City or town **NORMANDY**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6825 NATURAL BRIDGE RD.**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **KATHERINE KELLY**
 3. (b) If veteran, name war.....
 3. (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **7**
 year **1948** hour..... minute **6 A.M.**
 21. I hereby certify that I attended the deceased from **6-18-48**
 19....., to **7-7-48**, 19**48**
 that I last saw her alive on **7-6-48**, 19**48**
 and that death occurred on the date and hour stated above.
 Duration

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **WIDOW**
 6. (c) Age of husband or wife if alive **25 1/2** years
 7. Birth date of deceased **APRIL 25 1866**
 (Month) (Day) (Year)

Immediate cause of death.....
Cerebral hemorrhage 7 days
 Due to **Arteriosclerosis**
 Due to **530**
 Other conditions **Paralysis Agitans**
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
82 2 12 hr. min.
 9. Birthplace **PA.**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **AT HOME**

PHYSICIAN
 Major findings: **none**
 Of operations.....
 Of autopsy **none**
 Underline the cause of which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....
 12. Name **JOHN GRAHAM**
 13. Birthplace **IRELAND**
 (City, town, or county) (State or foreign country)
 14. Maiden name **BRIDGET M. CORMACK**
 15. Birthplace **PA.**
 (City, town, or county) (State or foreign country)
 16. (a) Informant **Mr. Albert H. Mangelsdorf**
 (b) Address **238 Park Road**
 17. (a) **REMOVAL** (b) Date thereof **7/9/48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **PARLA, KAN.**
 18. (a) Signature of funeral director **J. Miller**
 (b) Address **5765 DELAWARE BLVD**
 19. (a) **7-7-48** (b) **Carol A. Thompson**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **no**
 (b) Date of occurrence **none**
 (c) Where did injury occur? **none**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **none**
 (Specify type of place)
 While at work? **no** (e) Means of injury **none**
 23. Signature **M. E. Staehle** (M. D. or other) **M.D.**
 Address **7124 Natural Bridge** Date signed **7-7-48**

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

9-11-6

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 T. G. Farris
Licensed Embalmer No. 3384
P. O. Address St. Louis

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.