

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18434

State File No.

FILED MAY 24 1949

BIRTH NO. _____ REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 4531 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Warren</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrenton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>92</u>	
c. LENGTH OF STAY (in this place) <u>4</u> <u>10 mos.</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Katie Jane Memorial Home</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hattie</u> b. (Middle) _____ c. (Last) <u>McKernon</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 7, 1949</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 8, 1863</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>?</u>	13b. MOTHER'S MAIDEN NAME <u>?</u>	14. NAME OF HUSBAND OR WIFE _____
-----------------------------	------------------------------------	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Marge Guthier</u> ADDRESS <u>5470 Thrush St. Louis, Mo.</u>
--	-------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion acute</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Stroke subacute acute onset</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4/1 Severe atrophy of stem</u>		<u>4201</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from June 1, 1948, to Aug 7, 1949, that I last saw the deceased alive on May 6, 1949, and that death occurred at 10 p m., from the causes and on the date stated above.

23a. SIGNATURE <u>Arnold J. Hoelscher MD</u> (Degree or title)	23b. ADDRESS <u>Warrenton Mo</u>	23c. DATE SIGNED <u>5-9-49</u>
--	----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-10-49</u>	24c. NAME OF CEMETERY OR CREMATORY. <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
---	--------------------------	--	---

DATE REC'D BY LOCAL REG. <u>5-9-49</u>	REGISTRAR'S SIGNATURE <u>Floyd Logan</u>	421	25. FUNERAL DIRECTOR'S SIGNATURE <u>F.W. Nieburg & Co.,</u> ADDRESS <u>Warrenton, Mo.</u>
--	--	-----	---

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

109

RECEIVED

District Health Officer No. 9

District File Number

MAY 20 1949

Date Filed

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John Hieburg

Licensed Embalmer No. 3897

P. O. Address. Warrenton, 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.