

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 25 1949

State File No. **25063**
6174

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4229 Connecticut		e. STREET ADDRESS (If rural, give location) 4229 Connecticut	
3. NAME OF DECEASED (Type or Print) a. (First) Katie b. (Middle) Lonnon c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) 7-14-1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widow	8. DATE OF BIRTH March 17-1861
9. AGE (In years last birthday) 88		10. MONTH 3	11. DAY 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME John Becker		13b. MOTHER'S MAIDEN NAME Magerete Day	
14. NAME OF HUSBAND OR WIFE Richert Lonnon (Deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Lillian Ruby ADDRESS 4229 Connecticut	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocarditis ANTECEDENT CAUSES Arterio Sclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Age II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) 99	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 May 13, 1949 , to July 14, 1949 , that I last saw the deceased alive on July 14, 1949 , and that death occurred at 12:00 m., from the causes and on the date stated above.	
23a. SIGNATURE (Name or title) Walter Heidmann M.D.		23b. ADDRESS 3146 Morganford	
23c. DATE SIGNED July 15 49		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 7-18-49		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine	
24d. LOCATION (City, town, or county) (State) St. Louis		25. FUNERAL DIRECTOR'S SIGNATURE Wingbermuehle ADDRESS 3819 S Grand Blvd	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Casater		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE _____	

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

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.

Signed _____

J. Allen Hovis

Licensed Embalmer No. _____

4053

P. O. Address _____

St. Louis

Signed _____
Student Embalmer

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.