

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED SEP 2 1949

State File No. **28341**
7374
 Registrar's No. _____

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY MOO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS (1)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 12 HRS		d. STREET ADDRESS (If rural, give location) 16 3704 HARTFORD	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY HOSP.			
3. NAME OF DECEASED (Type or Print) a. (First) KATHERINE		b. (Middle) MENRAD	
c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) AUG 22 1949	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH AUG 26 1943
9. AGE (In years last birthday) 6		IF UNDER 1 YEAR Months 11 Days 27	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL GIRL		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL	11. BIRTHPLACE (State or foreign country) ST. LOUIS O
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME BEN MENRAD		13b. MOTHER'S MAIDEN NAME HELDGARD REINHART	
14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME _____		ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebratory Failure		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES (b) Poliomyelitis (Polio)			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (c) _____			
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 checked="" 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) ST. LOUIS MO			
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? OS			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:13 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Deed or title) W. E. Grant M.D.		23b. ADDRESS 2114 E Grand	
23c. DATE SIGNED 8-24			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE AUG. 24 1949	
24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS	
DATE REC'D BY LOCAL REG. AUG 24 1949		REGISTRAR'S SIGNATURE J. B. Lasater	
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Curtis		ADDRESS 2906 Grand	

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.

Student
Student Embalmer

Signed *Leo J. Budde*

Licensed Embalmer No. *342*

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.

