

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32055

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8180**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis |  | c. LENGTH OF STAY (in this place) 12 days   | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hosp. A                  |  | d. STREET ADDRESS (If rural, give location) 24 3806 Minnesota                         |  |

|  |                        |  |                                    |
|--|------------------------|--|------------------------------------|
| 3. NAME OF DECEASED (Type or Print) Katherine  |                        | 4. DATE OF DEATH (Month) (Day) (Year) 9/19/49                |                                    |
| 5. SEX Female  | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH Oct. 7, 1877      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home |                        | 10b. KIND OF BUSINESS OR INDUSTRY --                         | 9. AGE (In years last birthday) 71 |
| 11. BIRTHPLACE (State or foreign country) St. Louis, Missouri                                    |                        | 12. CITIZEN OF WHAT COUNTRY? USA                             |                                    |

|  |                                   |  |
|--|-----------------------------------|--|
| 13a. FATHER'S NAME Unknown   | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Henry                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. --        | 17. INFORMANT'S SIGNATURE OR NAME Edwin Nolte--3704 Fairview |

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal Failure  |  | INTERVAL BETWEEN ONSET AND DEATH Unknown |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Bilateral Hydro-nephrosis & Hydronephrosis            |  |  |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br>Coronary artery Disease<br>Distension of rt. heart |  |  |

|   |  |  |
|---|--|--|
| 19a. DATE OF OPERATION 15 Sept 49               | 19b. MAJOR FINDINGS OF OPERATION Fibrosarcoma of uterus  | 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) 576                              |
| 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? 215X  |

22. I hereby certify that I attended the deceased from 8-31, 1949, to 9-19, 1949, that I last saw the deceased alive on 9-19, 1949, and that death occurred at 8:00 p. m., from the causes and on the date stated above.

|  |                              |   |
|--|------------------------------|---|
| 23a. SIGNATURE Walter A. Mullarky, M.D.          | 23b. ADDRESS 3804 Wilmington | 23c. DATE SIGNED 21 Sept 49   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 9/22/49            | 24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.                 |
|  |                              | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri |

|                                      |                                     |   |                      |
|--------------------------------------|-------------------------------------|---|----------------------|
| DATE REC'D BY LOCAL REG. SEP 22 1949 | REGISTRAR'S SIGNATURE J. B. Lasater | 25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Weldner | ADDRESS 3634 Gravois |
|--------------------------------------|-------------------------------------|---|----------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

*me*

**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 *Delis J. Krupin* .....

Licensed Embalmer No. *3497* .....

P. O. Address *3634 Gravais* .....

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.