

FILED MAR 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10722

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2716**

1. PLACE OF DEATH a. COUNTY ST. LOUIS - MISSOURI		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (in this place) ONE DAY		d. STREET ADDRESS (If rural, give location) 19 4484 1/2 Delmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital			

3. NAME OF DECEASED (Type or Print) KATHERINE		a. (First)	b. (Middle) ----	c. (Last) LAWLER	4. DATE OF DEATH (Month) (Day) (Year) MARCH 17, 1950		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown - abt. 74	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 WES. Hours	IF UNDER 1 WES. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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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.	17. INFORMANT'S SIGNATURE OR NAME Barnes Hospital Records St. Louis Mo	ADDRESS Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Necrosis Small Bowel.		24 hrs.
	ANTECEDENT CAUSES DUE TO (b) Mesenteric occlusion DUE TO (c) Generalized Arteriosclerosis		24 hrs.
II. OTHER SIGNIFICANT CONDITION Conditions contributing to the death but not related to the disease or condition causing death.		Ventral Hernia.	50 yrs.

19a. DATE OF OPERATION 3/17/50	19b. MAJOR FINDINGS OF OPERATION Necrosis Small Bowel	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 5603
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **March 16, 1950**, to **Mar 17, 1950**, that I last saw the deceased alive on **Mar 17, 1950**, and that death occurred at **6:30 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wallace B. Walker M.D.	23b. ADDRESS Barnes Hospital,	23c. DATE SIGNED 3/17/50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE MAR 22 1950	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL MAR 22 1950	REGISTRAR'S SIGNATURE J. B. Fosater	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS 4301 Manchester Ave. St. Louis 19, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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 _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.