.S. No. 300
EV. 10-48

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22202

BIRTH NO. 84 [redacted] 49 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 1547

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

1. PLACE OF DEATH
a. COUNTY: St Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
c. LENGTH OF STAY (in this place): 20 A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Louis Co Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2239
d. STREET ADDRESS (If rural, give location): 23 1720 Mississippi

3. NAME OF DECEASED (Type or Print)
a. (First) Katheryn
b. (Middle) Nash
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): June 22 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec 24 1949
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 5 Days 29; IF UNDER 24 HRS. Hours Min.

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): St Louis Mo
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME: Francis Nash
13b. MOTHER'S MAIDEN NAME: Katheryn Cummins
14. NAME OF HUSBAND OR WIFE:

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 ADDRESS: Francis Nash 1720 Mississippi St Louis

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
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: 754.4
20. AUTOPSY? YES ☑ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

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 _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Herbert R Domke
Herbert R Domke Local Registrar of Vital Statistics
23b. ADDRESS: 651 So. Brentwood
23c. DATE SIGNED: 6/23/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/24/50
24c. NAME OF CEMETERY OR CREMATORY: Laurel Hill
24d. LOCATION (City, town, or county) (State): St Louis Mo

DATE REC'D BY LOCAL REG.: 6-23-50
REGISTRAR'S SIGNATURE: Herbert R Domke M.D. Jr.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ortmann Funeral Home 9222 Lackland Overland Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Al. C Ostmann

Licensed Embalmer No. 3478

P. O. Address .....

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.