

FILED OCT 26 1950

STANDARD CERTIFICATE OF DEATH

State File No. 35477

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8463	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS			
b. CITY OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) 2 days		c. CITY OR TOWN KIRKWOOD		4713	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo Baptist Hospital				d. STREET ADDRESS (If rural, give location) 308 PARKWOOD			
3. NAME OF DECEASED (Type or Print) CATHARINE MALLONEE WINGFIELD			4. DATE OF DEATH OCT-5-1950				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH DEC 16-1866	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) ST. LOUIS		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME LEONARD G MALLONEE		13b. MOTHER'S MAIDEN NAME CATHARINE G. MARTIN		14. NAME OF HUSBAND OR WIFE WILLIAM H WINGFIELD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME WILLIAM H WINGFIELD JR KIRKWOOD			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH _____	
		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 none		19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none			
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 321X			
22. I hereby certify that I attended the deceased from year , 19____, to 10/5/50 , 19____, that I last saw the deceased alive on 10/5/50 , 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Frank P. Gault, M.D. (Degree or title)				23b. ADDRESS 13^A N. GORE, Webster Groves, Mo.		23c. DATE SIGNED 10/6/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE OCT. 7-1950	24c. NAME OF CEMETERY OR CREMATORY OAK GROVE CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO		
DATE REC'D. BY LOCAL REG. OCT 7 1950		REGISTRAR'S SIGNATURE J. B. Lavater		25. FUNERAL DIRECTOR'S SIGNATURE PARKER-ALDRICH FUN. H. GROVES ADDRESS WEBSTER			

NOV 27 1950

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 *Leslie Welch* _____

Licensed Embalmer No. *4395* _____

P. O. Address *Wester Groves* _____

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.