

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25183
5672

State File No. _____
Registrar's No. _____

FILED JUL 16 1951

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

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, write RURAL and give township) **St. Louis Mo.**
 c. LENGTH OF STAY (in this place) **70 days**
 d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Louis Children's Hosp**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE **Illinois** b. COUNTY _____
 c. CITY (If outside corporate limits, write RURAL and give township) **Versailles**
 OR TOWN **8120**
 d. STREET ADDRESS (If rural, give location) **8**

3. NAME OF DECEASED
 a. (First) **Katherine** b. (Middle) **Latrina** c. (Last) **Roate**

4. DATE OF DEATH (Month) (Day) (Year)
June 22 - 51

5. SEX **Female**

6. COLOR OR RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **0**

8. DATE OF BIRTH **Feb 3 - 51**

9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.
3 22

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) **ILL 9**

12. CITIZEN OF WHAT COUNTRY? **Amer**

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME **Winona Roate**

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.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

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
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Seroguttan edema**
 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.

INTERVAL BETWEEN ONSET AND DEATH
3 mos

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

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? **517X**

22. I hereby certify that I attended the deceased from **4-12**, 19**51**, to **6-22**, 19**51**, that I last saw the deceased alive on **6-22**, 19**51**, and that death occurred at **5:33 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Dr. L. Shuster M.D.**

23b. ADDRESS **Childrens Hosp.**

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE **6-23-51**

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) **Versailles, Ill.**

DATE REC'D BY LOCAL REG. **JUN 25 1951**

REGISTRAR'S SIGNATURE **J. B. Karater**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Ronald W. Roate, Versailles, Ill**

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.