

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28498

State File No. ....

7191

Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY <u>0</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>St</u> b. COUNTY <u>Mo.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>5348 Queens Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bethesda Hospital</u>		e. CITY (If outside corporate limits, write RURAL and give township) <u>2079</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Katherine</u> b. (Middle) _____ c. (Last) <u>McKown</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 12, 1951</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W. Div.</u>	8. DATE OF BIRTH <u>Aug. 6, 1879</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>John Cashell</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Riley</u>	14. NAME OF HUSBAND OR WIFE <u>James McKown</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. James McKown, 5348 Queens Ave.</u>	ADDRESS _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>  <u>several years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u> 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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____
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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? <u>H43X</u>
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22. I hereby certify that I attended the deceased from 8-8, 1951, to 8-12, 1951, that I last saw the deceased alive on 8-12, 1951, and that death occurred at 5:24 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Thomas C. Pondace</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>4660 Maryland</u>	23c. DATE SIGNED <u>8/13/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 16, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>AUG 13 1951</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>	ADDRESS <u>3840 Lindell Blvd.</u>
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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.....

*W. H. VanMatre*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

**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.