

FILED OCT 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31516**
Registrar's No. **8470**

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD—
 Information from heart failure from family

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis 2199		
d. FULL NAME OF HOSPITAL OR INSTITUTION 3964 Washington Blvd.			d. STREET ADDRESS (If rural, give location) 19 3964 Washington Blvd. 0			
3. NAME OF DECEASED (Type or Print) Catherine		a. (First) George		b. (Middle) Hill	c. (Last)	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH June 16, 1860	9. AGE (In years last birthday) 91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pleasant Mound, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Madison Harper		13b. MOTHER'S MAIDEN NAME Mary Ann Edwards		14. NAME OF HUSBAND OR WIFE Leander		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. W.S. Kinder ADDRESS 3964 Washington Blvd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis				INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES (b) Scarlet Fever DUE TO (b)				20 yrs. ago	
	DUE TO (c) Inanition					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5-92X		
22. I hereby certify that I attended the deceased from 7/16, 1951 , to 9/24, 1951 , that I last saw the deceased alive on 9/22, 1951 , and that death occurred at 6:00 a.m. , from the causes and on the date stated above.						
23a. SIGNATURE (Type or Print) Carl Smith M.D.			23b. ADDRESS 2440 7 South Kings Highway		23c. DATE SIGNED 9/24/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-24-51	24c. NAME OF CEMETERY OR CREMATORY Carlyle, Ill.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. SEP 24 1951		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.		

NOV 14 1937

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 Robert M. Murray
Licensed Embalmer No. 3749
P. O. Address St. Louis, Mo.

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.