

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35572

318 1003

State File No. 9647  
Registrar's No. 9644

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give town)		b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

ST. LOUIS MO  
ST. LOUIS MO 2209  
NORTH LITTLE SISTERS OF POOR  
3225 N. FLORISSANT

3. NAME OF DECEASED (Type or Print)	a. (First)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
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KATHRYN SANDERS. Oct-30-51

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years at birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
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FE. W. W. V. SEPT-17-1890 61YRS. Months Days Hours Min.

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)	12. CITIZEN OF WHAT COUNTRY?
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PRACTICAL NURSE GRANITEVILLE MO. U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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LOUIS BURTON CATHERINE KEENAN WILLIAM SANDERS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
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None Mrs. Kathyleen Borgard Melstad

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)		
	ANTECEDENT CAUSES		

Cardio-vascular renal disease  
None  
None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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None

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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None

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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None

22. I hereby certify that I attended the deceased from Oct. 9 1951, to Oct. 30, 1951, that I last saw the deceased alive on Oct. 29, 1951, and that death occurred at 1:15 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Describe as title)	23b. ADDRESS	23c. DATE SIGNED
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Sumner A. Howe, M.D. 2435 Grand Blvd. 10-31-51

24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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Burial Nov-2-51 CALVARY Cem. St. Louis MO

DATE REC'D BY LOCAL REG. OCT 31 1951	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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Paul Smith M.D. E. J. Schuur 31254 AFAYETTE

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed.....

Licensed Embalmer No. *4814*

P. O. Address *3125 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.