

FILED JAN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42887

State File No. 11515
Registrar's No. 11515

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			STREET ADDRESS (If rural, give location) 1831 Allen		
3. NAME OF DECEASED (Type or Print) a. (First) Katherine		b. (Middle) _____	c. (Last) Duchek	4. DATE OF DEATH (Month) (Day) (Year) 12 26 51	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 9-11-1878	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwk		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME William Forst		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Bart Duchek (Deceased)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME August Duchek 1831 Allen			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) _____ ANTECEDENT CAUSES Cerebral Apoplexy Morbidity 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 _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334K			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1000 P. m. , from the causes and on the date stated above.					
23a. SIGNATURE Patrick E. Taylor Coxner		(Degree or title) _____	23b. ADDRESS 1300 Clark		23c. DATE SIGNED 12-26-51
24a. BURIAL, CREMATION, REMOVAL (Specify) cremation	24b. DATE 12-29-51	24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Mo		
DATE REC'D BY LOCAL REG. DEC 27 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Moydell Funeral Home 1926 Allen		

(Licensed Embalmer's Statement on Reverse Side)

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 me

working under my personal supervision.

Signed.....
Student Embalmer

Signed Dale A. Strammann
Student Embalmer No.....
Licensed Embalmer No. 4533
P. O. Address 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.