

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15125

State File No. \_\_\_\_\_

No. 300  
10-48

FILED APR 19 1952

REG. DIST. NO. 317

PRIMARY REG. DIST. NO. 6676

Registrar's No. 955

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis Co.,</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Wellston</b>	c. LENGTH OF STAY (in this place) <b>10 YRS.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Wellston</b>	<b>4801</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6512 Hobert Ave.,</b>		d. STREET ADDRESS (If rural, give location) <b>6512 Hobert Ave.,</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Catherine</b> b. (Middle) _____ c. (Last) <b>Stark</b>			4. DATE OF DEATH <b>April 8, 1952</b> (Month) (Day) (Year)		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 29, 1876.</b>	9. AGE (In years last birthday) <b>75</b>	# UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>James Walsh</b>	13b. MOTHER'S MAIDEN NAME <b>Ann Walsh</b>	14. NAME OF HUSBAND OR WIFE <b>John F. Stark Dec.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Estelle Gaskill, 6512 Hobert Ave.</b>

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) <b>Chronic Myocarditis</b>		<b>11 mo.</b>
	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. <b>Fracture Rt Hip</b>		<b>2 yrs</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>+ 222F</b>		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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July, 1949 to 4-8**, 19**52** that I last saw the deceased alive on **4-8**, 19**52** and that death occurred at **10 PM** from the causes and on the date stated above.

23a. SIGNATURE <b>Rev. R. R. [Signature]</b> (Degree or title)	23b. ADDRESS <b>730 Hodiament</b>	23c. DATE SIGNED <b>8-10-52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 11, 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Galvany Cem.</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

DATE REC'D BY LOCAL REG. <b>4-10-52</b>	REGISTRAR'S SIGNATURE <b>Herbert R. [Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Clark</b>	ADDRESS <b>1125 Hodiament Ave.,</b>
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DR. Leo Reilly  
730 Hodiament Ave.,

**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 .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

*John S. Reilly*  
Licensed Embalmer No. 41940  
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.