

FILED JUL 6 - 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **20919**

BIRTH NO. _____		REG. DIST. NO. 53		PRIMARY REG. DIST. NO. 3010		Registrar's No. 189	
1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau, Mo		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Mo		1007	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hosp				d. STREET ADDRESS (If rural, give location) 304 South West			
3. NAME OF DECEASED (Type or Print) Catherine		a. (First)		b. (Middle)		c. (Last) Allmeroth	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH 3/31/22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and State or Foreign Country) Ark		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Luber		13b. MOTHER'S MAIDEN NAME Bertha Ausman		14. NAME OF HUSBAND OR WIFE Kenneth Allmeroth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Kenneth Allmeroth Sikeston Mo		ADDRESS _____	
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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEPATITIS + OVARIAN Abscess (b) (operation) (c) Hysterectomy 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. NONE				INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION HEPATITIS + Salpingo oophoritis				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 6/15 , 19 53 , to 6/19 , 19 53 , that I last saw the deceased alive on _____, 19____, and that death occurred at 5:25 a.m., from the causes and on the date stated above.							
23a. SIGNATURE K. Allmeroth (Degree or title) MD				23b. ADDRESS Cape Girardeau Mo			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/23/53		24c. NAME OF CEMETERY OR CREMATORY Oran Cemetery		24d. LOCATION (City, town, or county) (State) Oran Mo	
DATE REC'D BY LOCAL REG 10-29-53		REGISTRAR'S SIGNATURE C. C. Summers		FURNERAL DIRECTOR'S SIGNATURE Wm. J. Jones		ADDRESS Oran Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

1941

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 John H. Hutton
Licensed Embalmer No. 2941
P. O. Address St. Louis

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.