

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8860**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>4 Weeks</b>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>4848 Sacramento Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Catherine</b>	b. (Middle) <b>Maude</b>	c. (Last) <b>James</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 11, 1953</b>
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5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 14, 1905</b>	9. AGE (In years last birthday) Months Days Hours Min. <b>48</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Secy.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Barnhardt &amp; Wood</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Patrick T. Maloney</b>	13b. MOTHER'S MAIDEN NAME <b>Olive Remington</b>	14. NAME OF HUSBAND OR WIFE <b>William D. James</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Patrick T. Maloney</b>	ADDRESS <b>4848 Sacramento</b>
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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, ashenia, 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>Acute myelocytic leukemia</b>		<b>2 mo</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic myelocytic leukemia</b>		<b>1 yr.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>204.1</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>None</b>	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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22. I hereby certify that I attended the deceased from **July, 1952** to **Sept 11, 1953**, that I last saw the deceased alive on **Sept 10, 1953**, and that death occurred at **9:00 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Herbert C. Fiegand, M.D.</b>	23b. ADDRESS <b>3720 Washington Blvd.</b>	23c. DATE SIGNED <b>Sept 11, 1953</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>9-14-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Mausoleum</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 12 1953</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Donnelly</b>	ADDRESS <b>3840 Lindell</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Herbert Weyand  
3720 Washington St  
Je. 3557  
2 to 5 PM

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....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 899  
P. O. Address W. Charles

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.