

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28951

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6995**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>University City</b> d. Is 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>Missouri Pacific Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>7347 Tulane</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Katherine</b>	b. (Middle) <b>G.</b>	c. (Last) <b>Havird</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 27-1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 1, 1889</b>	9. AGE (In years) (last birthday) <b>65</b>	IF UNDER 1 YEAR (Month) (Day) <b>6 26</b>	IF UNDER 24 HRS. (Hour) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Austria</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Frank Gelberman</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Klein</b>	14. NAME OF HUSBAND OR WIFE <b>Joshua Havird</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Joshua Havird- 7347 Tulane Ave.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>Reveral years</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Heart Disease</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 checked="" type="checkbox"/>
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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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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? <b>443X</b>
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22. I hereby certify that I attended the deceased from **1930, 1936, to July 27, 1954**, that I last saw the deceased alive on **7-27, 1954** and that death occurred at **8:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>R. B. Harrison M.D.</b>	(Degree or title)	23b. ADDRESS <b>607 No. Grand</b>	23c. DATE SIGNED <b>7-28-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>July 29-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>	24d. LOCATION (City, town, or county) (State) <b>Barry Ill.</b>
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DATE REC'D BY LOCAL REG. <b>JUL 28 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Herman Rindskopf Inc. 5215 Delmar Bl.</b>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

MAR 5 1956

**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.....  
Signature of Student Embalmer

Signed *John Ketter*.....

Licensed Embalmer No...38...

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