

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42508

11096

| | | | | | | | | | |
|---|-------------------------------|--|--|---|---|--|----------------------------|-----------------------------|----------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. <u>318</u> | | PRIMARY REG. DIST. NO. <u>1003</u> | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo. 0</u> | | c. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN <u>St. Louis</u> | | 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. <u>St. Anthonys Hospital</u> | | | | e. STREET ADDRESS (If rural, give location) <u>16 3933 Virginia Ave. 2169 0</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Catherine W.</u> b. (Middle) <u>Joyce</u> c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 4, 1954</u> | | | | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>1891 May 27, 1890</u> | | 9. AGE (In years last birthday) <u>63</u> | IF UNDER 1 YEAR Months _____ | IF UNDER 1 YEAR Days _____ | IF UNDER 1 YEAR Hours _____ | IF UNDER 1 YEAR Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo. 0</u> | | 12. CITIZEN OF WHAT COUNTRY? _____ | | | |
| 13a. FATHER'S NAME <u>Bernard Boegeman</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Gensia Brinkman</u> | | 14. NAME OF HUSBAND OR WIFE <u>Joseph M. Joyce</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Capt. Joseph M. Joyce 3933 Va. Ave.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>This does not mean the mode of dying, such as suffocation, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> | | | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis Sclerotic Myocarditis</u> | | | | ? | | | |
| | | 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? <u>4221</u> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>2/27/54</u> 19 <u>54</u> , to <u>Dec 4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Dec 3</u> , 19 <u>54</u> , and that death occurred at <u>4:50p</u> m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE <u>Frank J. ...</u> (Degree or title) <u>M. D.</u> | | | 23b. ADDRESS <u>3924 S. GRAND BLVD ST. LOUIS MO.</u> | | | 23c. DATE SIGNED <u>12/6/54</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>12-7-54</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>SS Peter & Paul Cem.</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | | | |
| DATE REC'D BY LOCAL REG. <u>DEC 6 1954</u> | | REGISTRAR'S SIGNATURE <u>Charles Smith MO</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Southern Funeral Home</u> | | ADDRESS <u>6322 S. Grand Blvd.</u> | | | |

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

DR. F. J. STANZE
3924 S. GRAND

11:30 TO 3:30
A.M. P.M.

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 *James J. Wyland Jr.*.....
Licensed Embalmer No. 14512.....

P. O. Address 6322 So. 8th.....

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.