

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6779**

FILED MAR 1 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 926

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY OR TOWN <u>St. Louis</u>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>15 days</u>		e. STREET ADDRESS (If rural, give location) <u>3645 Page Blvd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Catherine</u> b. (Middle) _____ c. (Last) <u>Hart</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7, 1955</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>S.</u>	8. DATE OF BIRTH <u>Aug. 18, 1880</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>James Hart</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine McKeon</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</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>Miss Nellie Hart, 3645 Page Blvd.</u>	

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, asthma, 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) <u>Atypical pneumonia</u>		<u>2.5 wks</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>Fracture Right Hip</u>		<u>Un certain</u> <u>15 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>2/4/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture Right Hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u> <u>Mo.</u> <u>Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan 23 1953 1Pm.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in room at home</u>	

22. I hereby certify that I attended the deceased from 1/22, 1955, to 2/7, 1955, that I last saw the deceased alive on 2/7, 1955, and that death occurred at 4:20 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Thomas W. Tarkenton M.D.</u>		23b. ADDRESS <u>4660 Marquette St. St. Louis Mo.</u>		23c. DATE SIGNED <u>2/8/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb. 10, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>					

DATE REC'D BY LOCAL REG. <u>2-8-55</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donohue</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly 840 Lindell Blvd.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

G.W.

MS MAR 30 1962

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 [Signature].....

Licensed Embalmer No. 469.....

P. O. Address 3840 Linden.....

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.