

FILED MAR 31 1955

STANDARD CERTIFICATE OF DEATH

State File No. 10365
2490

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospt.				d. STREET ADDRESS (If rural, give location) 1121 Etzel Terrace 2059					
3. NAME OF DECEASED (Type or Print) a. (First) Katherine		b. (Middle)		c. (Last) Weiss		4. DATE OF DEATH (Month) (Day) (Year) 3/17/55			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 1/24/1867		9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Dress Maker		11. BIRTHPLACE (State or foreign country) Hecker, Ill.		12. CITIZEN OF WHAT COUNTRY? US			
13a. FATHER'S NAME Leonard Weiss			13b. MOTHER'S MAIDEN NAME Katherine Hoecker		14. NAME OF HUSBAND OR WIFE None				
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 ADDRESS Josephine Fogassey 1121 Etzel Ter.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Obstruction & Perforation of sigmoid colon & peritonitis.</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Due to carcinoma of sigmoid</i> DUE TO (b) <i>Cardiac failure</i> DUE TO (c) <i>Cardiac failure</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cardiac failure</i>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 3/16/55		19b. MAJOR FINDINGS OF OPERATION <i>Perforation & obstruction of colon & small bowel & peritonitis</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? 153x			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from <u>12 May 1955</u> , to <u>18 May 1955</u> , that I last saw the deceased alive on <u>17 May 1955</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <i>Arthur P. Dalton M.D.</i> (Degree or title)				23b. ADDRESS <i>1508 Olive St. St. Louis</i>		23c. DATE SIGNED <i>3/18/55</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/19/55		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. MAR 18 1955		REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Jos. W. Clark 1125 Hodiamont Ave.</i>					

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

4500 Olive St.

P.O. 1 1604

2-4pm.

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Alfred J. Bredeken*

Signed.....
Student Embalmer

Licensed Embalmer No. *2663*

P. O. Address *11257 Hodiann*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.