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FILED JUL 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **20598**BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **544** Registrar's No. **1450**

4. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KIRKWOOD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS	
c. LENGTH OF STAY (In this place) 2 months		d. STREET ADDRESS (If rural, give location) 1717 SUBURBAN TRACKS	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK NURSING HOME			

3. NAME OF DECEASED (Type or Print) a. (First) KATIE b. (Middle) _____ c. (Last) COMER			4. DATE OF DEATH (Month) (Day) (Year) JUNE 25 1955		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCT. 15, 1880	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) SAPPINGTON, MO.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME NIS BUNDESEN	13b. MOTHER'S MAIDEN NAME MARY REICHAERT	14. NAME OF HUSBAND OR WIFE THOMAS M. COMER
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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) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MA Leslie Ht	ADDRESS 540a S. Elm Webster Groves
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial Infarction, Chronic		
ANTECEDENT CAUSES		DUE TO (b) unknown		
DUE TO (c) unknown		II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		none		

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) 4222
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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
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22. I hereby certify that I attended the deceased from **1 June, 1955**, to **21 June, 1955**, that I last saw the deceased alive on **21 June, 1955**, and that death occurred at **6:00 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE John B. Smith	(Degree or title)	23b. ADDRESS 9929 Manchester Way, Richmond, 24, MO.	DATE SIGNED 6-25-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 6-27-55	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. 6/25/55	REGISTRAR'S SIGNATURE Herbert L. Donke MD	25. FUNERAL DIRECTOR'S SIGNATURE MITTELBERG FUNERAL HOME	ADDRESS 723 W. LOCKWOOD AVE WEBSTER GROVES, MO.
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(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed

J W Bentley

Licensed Embalmer No.

3657

P. O. Address

St Louis 8 Mo

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.