

FILED MAY 3 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14542

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3790**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN St. Louis		a. STATE Missouri b. COUNTY St. Louis	
c. LENGTH OF STAY (In this place) 12 days		c. CITY OR TOWN Pine Lawn 4001	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 4225 Dardenne Drive		(If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Kathryn	b. (Middle) Agnita	c. (Last) Dill	4 - 16 - 1956	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7 - 1 - 1898	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days		IF UNDER 18 Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
13a. FATHER'S NAME Edward W. Barrett		13b. MOTHER'S MAIDEN NAME Annie Moran		14. NAME OF HUSBAND OR WIFE William P. Dill
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 William P. Dill ADDRESS 4225 Dardenne Dr.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis		ANTECEDENT CAUSES Chronic Bronchial Cardiac Asthma		March 27 '56	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Bronchial Cardiac Asthma			
		DUE TO (c) Chronic Jaccard Degeneration			
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 checked="" 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?	

22. I hereby certify that I attended the deceased from **April 4th 1956** to **April 12th 1956**, that I last saw the deceased alive on **4-5-56**, and that death occurred at **1:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Clarence G. Drum (Degree or title)		23b. ADDRESS 1927a Union		23c. DATE SIGNED 4-16-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/19/56		24c. NAME OF CEMETERY OR CREMATORY Galvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri					

DATE REC'D BY LOCAL REG. APR 17 1956		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral ADDRESS 1905 Union Blvd.	
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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.....
Signature of Student Embalmer

Signed..... *Albert R. Thompson*

Licensed Embalmer No. 42

P. O. Address *St. Louis*

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.