

Health, Welfare, Public Service

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All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28648

STATE FILE NUMBER

FILED SEP 6 1956

318

1003

7293

Registration District No. Primary Registration District No. Registrar's No.

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|---|----------------------------------|---|---|--|--|
| 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) 4703 Varrelman | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle CATHERINE Last KATZUNG | | | 4. DATE OF DEATH AUGUST 6, 1956 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/14/1879 | 9. AGE (In years last birthday) 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) New York, N.Y. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Faust | | | 14. MOTHER'S MAIDEN NAME Sophie Seiferth | | |
| 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 Sister Address Anna M. Buchrucker 3452 Keokuk St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of left breast DUE TO (b) with metastases to liver, lung DUE TO (c) & lymph nodes CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 170 x |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 7/27/56 to 8/6/56 and last saw her/him alive on 8/6/56 Death occurred at 9:50 A.M. m on the day stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) John Allen, M.D. | | | 22b. ADDRESS 1515 LAFAYETTE AVE. | | 22c. DATE SIGNED 8/6/56. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/9/56 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
| 24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette Ave. | | 25. DATE RECD. BY LOCAL REG. AUG 8 1956 | | 26. REGISTRAR'S SIGNATURE Carl Smith M.D. | |

(Licensed Embalmer's Statement on Reverse Side)

MS JUL 19 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Joseph Bollmer*
Licensed Embalmer No. *410*

P. O. Address *3125 Lafayette*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.