

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. AIT  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JAN 7 1957

40635  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1381

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Joseph</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp.</u> Length of stay in lb <u>74 yrs.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>Saint Joseph</u> <u>0117</u> d. STREET ADDRESS <u>209 So. 15th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Katke</u> Last <u>Katke</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1882</u> 74		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (City and state or country) <u>St. Joseph Missouri</u>	
13. FATHER'S NAME <u>Fred Pasternak</u>		14. MOTHER'S MAIDEN NAME <u>Mary // Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> *****		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Virgil Ashford, Kansas City Mo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhages with right Hemiplegia.</u> DUE TO (b) <u>Cardio-vascular Degenerative Disease</u> DUE TO (c) _____ 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 <u>1 day</u>  <u>Unk.</u>	
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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE _____			
21. I attended the deceased from <u>11-5-1948</u> , to <u>12-21-56</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>12-21-56</u> Death occurred at <u>9:45 P.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Arthur W. King MD</u> (Degree or title)			22b. ADDRESS <u>Tootle Building</u> <u>St. Joseph, Mo.</u>		
22c. DATE SIGNED <u>12/24/56</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
23b. DATE <u>Dec. 24, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Saint Joseph Mo.</u>		24. FUNERAL DIRECTOR <u>Barry-Harman F.H.</u> ADDRESS <u>St. Joseph, Mo</u>			
25. DATE RECD. BY LOCAL REG. <u>Jan 2, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Evelyn M. Allison</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Charles M. Harmon*.....

Licensed Embalmer No. *44*

P. O. Address *Waltham*

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.