

FILED APR 12 1957

STANDARD CERTIFICATE OF DEATH

11192
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2505**

S. 300
7. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST LOUIS MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.		d. STREET ADDRESS 3724 N 25th	
3. NAME OF DECEASED (Type or print) CATHERINE THOMASSEN		4. DATE OF DEATH MAR. 12, 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 16 1889
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	9b. KIND OF BUSINESS OR INDUSTRY NONE	9c. AGE (In years last birthday) 67	
10. BIRTHPLACE (City and state or country) DARMSTADT GERMANY		11. CITIZEN OF WHAT COUNTRY? USA	
12. FATHER'S NAME UNKNOWN METZLER		13. MOTHER'S MAIDEN NAME UNKNOWN WEBER	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no of unknown) No		15. SOCIAL SECURITY NO. NONE	
16. INFORMANT ARN W. THOMASSEN		17. ADDRESS 3724 N 25th	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			331+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 3/6/57 to 3/12/57 and last saw her/him alive on 3/12/57 Death occurred at 9:10 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leroy P. Orttweyer M.D.		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 3/12/57.
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 3-14-57	23c. NAME OF CEMETERY OR CREMATORY VALHALLA CHAPEL OF MEMORIES	23d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY
24. FUNERAL DIRECTOR Suedmeyer's Sons	ADDRESS 3934 N-20th	25. DATE RECD. BY LOCAL REG. MAR 13 '57	26. REGISTRAR'S SIGNATURE Carl Smith MO

21.01.19

DATE

BY

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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 *Justin W. Dietrich*

Licensed Embalmer No. *432*

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.