

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29626

STATE FILE NUMBER

318

1003

7020

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

| | | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|---|--|
| 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 | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1123 Childress | | | Length of stay in 1b | | STREET ADDRESS 1123 Childress | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Mary Ann Katterhenry | | | | 4. DATE OF DEATH Month July Day 28 Year 1957 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 13, 1934 | | 9. AGE (In years last birthday) 23 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist-Royal Management Inc | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Chicago, Ill | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William Katterhenry | | | | 14. MOTHER'S MAIDEN NAME Sarah Smiley | | | | | |
| 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. No | | 17. INFORMANT Address Wm Katterhenry 1123 Childress | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia in terminal stages | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH abt 30 Mon | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) _____ | | DUE TO (c) _____ | | 705.4 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 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 8:00 Jan 1957 , to July 28 1957 and last saw her alive on July 27, 1957 . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE Sam T Beam MD | | | | 22b. ADDRESS 35 W Central - Spring - Ok 7/28/57 | | 22c. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | |
| Removal | | 7-29-57 | | | | Pittsburg, Mo, Pennsylvania | | | |
| 24. FUNERAL DIRECTOR Kriegshauser 4228 So. Kingshighway | | | | 25. DATE RECD. BY LOCAL REG. JUL 29 1957 | | 26. REGISTRAR'S SIGNATURE Carl Smith MD mfb | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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-56

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

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 *Richard W. Storrs*

Licensed Embalmer No. *46*

P. O. Address

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.