

Health, Welfare  
Public  
Service

300  
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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29649  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's 7094

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <b>St. John's Hosp</b>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>4920 Hooke Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>A.</b> Last <b>Klots</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 30, 1877</b>		9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Ryan</b>				14. MOTHER'S MAIDEN NAME <b>Dont Knew</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Emmet K. Gibbons 5700 Murdoch Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of rectum with cerebral &amp; hepatic metastases.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>153x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>9-1-56</b> to <b>7-29-57</b> and last saw her <sup>alive</sup> on <b>7-29-57</b> Death occurred at <b>4:08 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Syvester A. Fleete M.D.</b>				22b. ADDRESS <b>18 So. Kingshighway</b>		22c. DATE SIGNED <b>7-30-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>8-2-1957</b>	<b>Calvary Cemetery</b>		<b>St. Louis Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Cullinane Bros. 3320 N. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 30 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

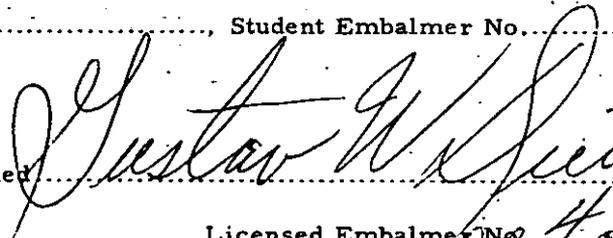
(Licensed Embalmer's Statement on Reverse Side)

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.....



Licensed Embalmer No. 49

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.