

with, welfare, public service

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29780

STATE FILE NUMBER 7667

FILED SEP 4 1957

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor</u>		Length of stay in lb <u>7 years</u>		d. STREET ADDRESS (If outside, give location) <u>3400 S. Grand Blvd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Merz</u> Last <u>Merz</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 20, 1869</u>		9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
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 <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Blase</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Steves</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 Address <u>Sr. Marie Jean, Supr., 3400 S. Grand Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>General arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General Arteriosclerosis</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) <u>420.0</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u> <u>Yes</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 a. m. p. m. Month, Day, Year							
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.) <u>Jan 1957</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo.</u>		COUNTY STATE	
21. I attended the deceased from <u>Jan 1957</u> to <u>8/16/57</u> and last saw her alive on <u>8/14/57</u> Death occurred at <u>3:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. Mezera</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>8059 Watson Rd.</u>		22c. DATE SIGNED <u>8/16/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8-19-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Millwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Millwood, Mo.</u>		
24. FUNERAL DIRECTOR <u>E. Allen Keithly - Fallon Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 16 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

S.P.

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 *E. Allen Keithly*.....

Licensed Embalmer No....*8*

P. O. Address *G. Fallon*

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.