

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1957

STATE FILE NUMBER
33853
8954

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

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 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 Missouri 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	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deconess Hospital		Length of stay in 1b		d. STREET ADDRESS 3318 Nebraska Ave (If outside, give location)	
3. NAME OF DECEASED (Type or print) KATHERINE (KATIE) Martinuk (Martynuk)		First Middle Last		4. DATE OF DEATH Sept. 23 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April, 13, 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 68	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		11. BIRTHPLACE (City and state or country) Austria	
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. 498-20-6753		17. INFORMANT Address Walter Martinuk 3318 Nebraska	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cecum, with peritoneal, mesenteric, and liver metastases.				INTERVAL BETWEEN ONSET AND DEATH about 9/2/57 to 9/23/57	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 153x					
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 8/12/57 to 9/23/57 and last saw her alive on 9/22/57 Death occurred at 12:15 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James G. Geiggo, M.D.		22b. ADDRESS 7820 Canfield, Clayton, Mo.		22c. DATE SIGNED 9/25/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/26/57		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	
24. FUNERAL DIRECTOR CHULICK UND. CO.		ADDRESS 1722 S. Jefferson		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
25. DATE RECD. BY LOCAL REG. SEP 25 57		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.			

8001

812

ISSUED

DATE

TIME

Address of deceased

Address of embalmer

(Signature of deceased)

Signature of deceased

x

and

Signature of embalmer

Signature of embalmer

Signature of embalmer

Signature of embalmer

FORM NO. 188 REV. 1-1-41 (1-1-41-82)

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.....
Harvey Kahle
Licensed Embalmer No. 459

P. O. Address *Flouissant*

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.