

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42087
STATE FILE NUMBER
11021

FILED NOV 22 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11021

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) TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 08 INSTITUTION Deaconess Hospital			Length of stay in 1b 2 days		STREET ADDRESS (If outside, give location) 06 5569 Cote Brilliant		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last KATHRYN BARBARA HERWIG				4. DATE OF DEATH Month Day Year Nov. 17-1957			
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 30, 1879		9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) employee			10b. KIND OF BUSINESS OR INDUSTRY Modern Jacket Co. St. Louis, Missouri		11. BIRTHPLACE (City and state or country) C St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME. unknown			
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. 488-01-1307		17. INFORMANT Address Vincent Bollam-1904 Clara Avenue			
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>Auricular fibrillation</u> About <u>10</u> years Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic heart disease.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10</u> years
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>							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.) None				
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 <u>Jan. 1952</u> to <u>Nov. 17, 1957</u> and last saw her <u>him</u> alive on <u>11-17-57</u> Death occurred at <u>2:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>46. A. [Signature] M.D.</u>				22b. ADDRESS <u>19 E. Lockwood Ave., Webster Groves 19, Mo.</u>		22c. DATE SIGNED <u>11-18-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE <u>11-19-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton & Sons-7233 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 18 57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Dr. H. Goodrich
19 E. Lockwood
WO 2-3200

JAN 25 1958

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 *Arnold W. Schoene*

Licensed Embalmer No. *386*

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.