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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-020165
STATE FILE NUMBER 5423

FILED JUN 11 1958

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

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS Mo — Inside Limits Yes ☐ No ☐

c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 38 ENROUTE CITY Hosp. — Length of stay in 1b

d. STREET ADDRESS (If outside, give location) 72490 2910 CALIFORNIA — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: KATHERINE SMITH

4. DATE OF DEATH Month Day Year: MAY 21 1958

5. SEX: Female

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: MAR. 29 1877

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WIDOW

10b. KIND OF BUSINESS OR INDUSTRY: AT Home

11. BIRTHPLACE (City and state or country): Missouri O

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: HANS FINCK

13b. MOTHER'S MAIDEN NAME: SOPHIE PULS

14. NAME OF HUSBAND ~~OR WIFE~~: HARRY SMITH (DEC'D

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.: None

17. INFORMANT Address: ANNA FINCK 2910 CALIFORNIA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cardiac Dilatation	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	widespread Myocarditis	3 yrs.
DUE TO (c)	Interstitial Nephritis	20 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): auricular fibrillation - Senility 4331

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE None

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: None

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Dec. 10-1956, to May 21-58 and last saw her/him alive on May 20-1958
Death occurred at 12:30 am. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Jno Chlaubek Jr. MD

22b. ADDRESS: 2767 Gravois Ave

22c. DATE SIGNED: 5-23-58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: MAY 23 1958

23c. NAME OF CEMETERY OR CREMATORY: NEW ST. MARCUS

23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR ADDRESS: Thomas Kutis 2906 Gravois

25. DATE RECD. BY LOCAL REG.: MAY 23 '58

26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

V 3-9477

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 Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis