

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027205
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7247**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3448 Osage Ave.		d. STREET ADDRESS (If outside, give location) 3448 Osage Ave.	

3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MC KINNEY			4. DATE OF DEATH Month Day Year Abt. 7/26/58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/02	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wk.		

10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Fred Swanson		13b. MOTHER'S MAIDEN NAME Marie Conway		14. NAME OF HUSBAND OR WIFE Howard McKinney	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y, N, or, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Fred Swanson-3448 Osage Ave.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Arterio Sclerosis			
DUE TO (c) 260X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 p.m.					

20d. INJURY OCCURRED WHILE AT <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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title) [Signature]		22b. ADDRESS 1300 Elm		22c. DATE SIGNED 7/23/58	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/25/58		23c. NAME OF CEMETERY OR CREMATORY New St. Marons Cem.		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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24. FUNERAL DIRECTOR ADDRESS MOYDELL FUNERAL HOME-1926 ALLEN		25. DATE RECD. BY LOCAL REG. JUL 25 58		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
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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.

USE ONLY BLACK INK OR RIBBON. TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

300
1-57

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 *Reginald K. Lehmann*

Licensed Embalmer No. 3395.....
P. O. Address St. Louis 4 Mo.....

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.