

By Affidavit of Informant THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038045

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9982

S. 300.
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON. TYPEWRITE IF POSSIBLE.

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3931 Vista</i> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <i>2189 3931 Vista</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Katherine Mohr</i> | | | 4. DATE OF DEATH Month Day Year <i>10/19/1958</i> |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 3 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10/19/1896</i> |
| 9. AGE (In years) <i>62</i> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <i> Tenn.</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 13a. FATHER'S NAME <i>James Kilgore</i> | 13b. MOTHER'S MAIDEN NAME <i>Alice King</i> |
| 14. NAME OF HUSBAND OR WIFE <i>Nelson</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <i>no</i> | 16. SOCIAL SECURITY NO. |
| 17. INFORMANT <i>Mrs. Ida Perkins</i> | | Address <i>3931 Vista</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of uterus with metastases to pelvic and cervical lymph nodes, rectum.</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>22 months</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | <i>174x</i> |
| 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 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.) | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 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 <i>June 6, 1958</i> to <i>October 19, 1958</i> and last saw <i>her</i> alive on <i>October 19, 1958</i> Death occurred at <i>12:20 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>John T. Lawton M.D.</i> | | 22b. ADDRESS <i>634 N. Grand Blvd.</i> | 22c. DATE SIGNED <i>Oct. 20, 1958</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | 23b. DATE <i>10/22/58</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive Cemetery</i> | 23d. LOCATION (City, town, or county) (State) <i>Mt. Olive Illinois</i> |
| 24. FUNERAL DIRECTOR <i>Joe A. Howard</i> | | ADDRESS <i>1619 So. Grand</i> | 25. DATE RECD. BY LOCAL REG. <i>OCT 20 58</i> |
| 26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i> | | | |

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 *John D. Dennehy*
Licensed Embalmer No. *4194*
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.