

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007170

STATE FILE NUMBER

2 1601

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI, COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		d. STREET ADDRESS 2301 5 th 10 th	

3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE M. HALL			4. DATE OF DEATH Month Day Year 2 13 59			
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27 - 1884	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, except in hospital) <i>at home</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME M.P. Connor	13b. MOTHER'S MAIDEN NAME No T KNOWN	14. NAME OF HUSBAND OR WIFE Deceased.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Charles W. Haberstrok 4659 Alaska
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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) cerebral hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 331X	
	DUE TO (c)	
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"/> 2

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 <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 2/9/59 to 2/13/59 and last saw her alive on 2/13/59
Death occurred at 3:10 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. James Vaccarella M.D.	(Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 2/14/59
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL OF BODY Burial	23b. DATE 2-16-1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION (City, town, or county) St. Louis Mo (State)
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24. FUNERAL DIRECTOR R. J. Bermack 3819 26 Grand Blvd	25. DATE RECD. BY LOCAL REG. FEB 15 '59	26. REGISTRAR'S SIGNATURE Roan Smith M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Robert M. Murray

Licensed Embalmer No. 3749
P. O. Address St. Louis 11

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.