

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1959

59-030124

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 188

| | | | | | | | | | |
|--|---|---|--|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | | | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> | | Length of stay in 1b <u>6 Days</u> | | c. CITY OR TOWN <u>Rock Hill</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) <u>9901 Kenyon Ct.</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Breier</u> Last <u>Breier</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1959</u> | | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 16 81</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (City and state or country) <u>Unknown</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | |
| 13a. FATHER'S NAME <u>Louis Koehler</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Viginia Bone</u> | | | 14. NAME OF HUSBAND OR WIFE <u>John</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | | 16. SOCIAL SECURITY NO. <u>No.</u> | | 17. INFORMANT <u>Brentwood Mo. John Breier 2515 Bremerton</u> | | | | |
| 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>unknown</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.) | | | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> | 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>August 7, 1959</u> to <u>August 17, 1959</u> and last saw her alive on <u>August 17, 1959</u> Death occurred at <u>2:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>Eugene J. Canty, M.D.</u> | | | | 22b. ADDRESS <u>St. Charles, Mo</u> | | 22c. DATE SIGNED <u>Aug 17, 1959</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 14 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> | | 23d. LOCATION (City, town, or county) <u>ST. Louis</u> | | STATE <u>MA.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Louis A. Bappone</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>Aug 12 59</u> | | 26. REGISTRAR'S SIGNATURE <u>Marguerite Wilson</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

J. Gustav W. [Signature]

Licensed Embalmer No. 432

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.