

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034723

FILED VS. SEP 28 1959 317

Primary Registration District No. 590 Registrar's No. 2551

STATE FILE NUMBER

ENDED

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Rock Hill</b>       |  | Length of stay in 1b<br><b>11-mon.</b>  | c. CITY OR TOWN <b>Richmond Heights</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <b>9809 Manchester Road<br/>Rock Hill Rest Home</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1136 Surry Hills Drive</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |                               |   |   |   |   |
|---|-------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Katherine Haren</b>                                    |                               |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 24, 1959</b>       |   |   |
| 5. SEX<br><b>F.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-17-1882</b>                              | 9. AGE (last birthday)<br><b>77</b>                               | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>            |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Mo</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                      |   |
| 13a. FATHER'S NAME<br><b>William Haren</b>  |                               | 13b. MOTHER'S MAIDEN NAME<br><b>Katie M. Byrne</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>single</b>                      |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |                               | 16. SOCIAL SECURITY NO.<br><b>no</b>  |   | 17. INFORMANT Address<br><b>William E. Haren Los Vegas Nevada</b> |   |

DOCUMENT

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)  |  |   |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

MEDICAL CERTIFICATION

|  |   |  |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m. p.m.  |   |  |
| 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 <b>Oct 20 1958</b> to <b>Sept. 24</b> and last saw her <sup>her</sup> alive on <b>9-21-59</b><br>Death occurred at <b>8:45 am.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |

AFFIDAVIT OF

|  |                               |   |   |
|--|-------------------------------|---|---|
| 22a. SIGNATURE (Degree or title)<br><b>C. S. Morklin M.D.</b>              |                               | 22b. ADDRESS<br><b>3707 Potomac</b>                           | 22c. DATE SIGNED<br><b>9-24-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                | 23b. DATE<br><b>9/28/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Missouri</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>John J. Donnelly 3840 Lindell Blvd.</b> |                               | 25. DATE RECD. BY LOCAL REG.<br><b>9-25-59</b>                | 26. REGISTRAR'S SIGNATURE<br><b>John B. Murphy M.D.</b>                     |

**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 *W. H. Salton*

Licensed Embalmer No. 4699

P. O. Address 3840 1st St. S.W.

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.