

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015925

STATE FILE NUMBER

AMENDED  Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1060  
**FILED APR 27 1961**

1. PLACE OF DEATH a. COUNTY <b>Mo</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>DEPEND HTGS.</b>		Length of stay in lb <b>5-days</b>	c. CITY OR TOWN <b>St Louis Mo</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5833 Devonshire Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>G</b> Last <b>Jostedt</b>	4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>61</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1891</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Daniel Egan</b>	13b. MOTHER'S MAIDEN NAME <b>Nora Bailey</b>	14. NAME OF HUSBAND OR WIFE <b>Theodore (Deceased)</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Daniel Jostedt 10942 St Francis Lane</b>
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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) <b>Emboli to Brain + Kidney</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Auricular thrombus + fibrillation</b> <b>18 mos.</b>
	DUE TO (c) <b>Arteriosclerotic Heart Disease</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>	
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	

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.)
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20c. TIME OF INJURY Hour <b>9:00</b> a.m. p.m. Month, Day, Year
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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
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21. I attended the deceased from <b>Nov 3, 1958</b> to <b>April 16, 1961</b> and last saw him/her alive on <b>April 16, 1961</b> Death occurred at <b>9:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Arthur J. Donnelly</b>	22b. ADDRESS <b>16 Hampton Village</b>	22c. DATE SIGNED <b>4/17/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>4-20-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>
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24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b> ADDRESS <b>3840 Lindell Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>4-18-61</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 Tom S. Salter

Licensed Embalmer No. 4699

P. O. Address 3840 Luedell

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.