

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7216

AMENDED

FILED AUG 8 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 5 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3815 Michigan ave.
3. NAME OF DECEASED (Type or print) First Katherine Middle E. Last Klages		4. DATE OF DEATH Month August Day 3 Year 1961	

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1891	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Belleville, Illinois	12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME Patrick Coghlan	13b. MOTHER'S MAIDEN NAME Bridget Gallagher	14. NAME OF HUSBAND OR WIFE Oscar E.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. no	17. INFORMANT Leo J. Klages	Address 3836 Eiler St.
--	--------------------------------------	---------------------------------------	----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH from 7/30 to 8/3
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pulmonary infarction	
	DUE TO (c) 260X	

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	
---	--	---	--

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.)
---	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 7/30/61 to 8/3/61 and last saw her/him alive on 8/3/61.
Death occurred at 7.30 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ralph Bergmo (Degree or title)	22b. ADDRESS 3203 S. Graw	22c. DATE SIGNED 8/3/61
---	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 7, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) 1215 Lemay Ferry Rd. Lemay, Mo.
---	----------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 7814 S. Broadway	25. DATE RECD. BY LOCAL REG. AUG 3 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
---	---	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Bill E. Drannon

Licensed Embalmer No. 4264

P. O. Address St Louis Mo

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.