

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

9785

-61-038802

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis Mo.</b>		Length of stay in lb <b>2 Weeks</b>	c. CITY OR TOWN <b>Florissant Missouri</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2645 Narraganset Dr.</b>
a. STATE <b>Missouri</b>		b. COUNTY <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>VICTOR</b>	<b>H.</b>	<b>KATH</b>	<b>October</b>	<b>21</b>	<b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/1917</b>	9. AGE (last birthday) <b>44</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	11. BIRTHPLACE (City and state or country) <b>Janisville, Wisc.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Fredrick Kath</b>		13b. MOTHER'S MAIDEN NAME <b>Zilla Stewart</b>		14. NAME OF HUSBAND OR WIFE <b>Ruth Kath</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruth Kath Florissant Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Brain Tumor - Left parietal - (Glioblastoma multiforme - malignant)</b>		<b>3 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<b>193.0</b>

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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 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 10/7/61 to 10/21/61 and last saw her alive on 10/21/61  
 Death occurred at 10<sup>30</sup> a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Henry E. Lattinville, M.D.</b>	22b. ADDRESS <b>950 Francis Place, St. Louis 5, Mo.</b>	22c. DATE SIGNED <b>10/23/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/26/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ascension Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Libertyville, Ill.</b>
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24. FUNERAL DIRECTOR <b>White-Mullen Mortuary Inc. Ferguson Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 23 1961</b>	26. REGISTRAR'S SIGNATURE <b>Coal Smith, M.D.</b>
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BY AFFIDAVIT OF

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Reinhold K. Lohman

Licensed Embalmer No. 3395

P. O. Address St Louis 3

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.