SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10849 -61-042260 STATE FILE NUMBER

FILED DEC 1 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

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2947 Easton — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2947 Easton — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Bertha Middle: Last: Catlett

4. DATE OF DEATH Month: 11 Day: 18 Year: 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒

8. DATE OF BIRTH: 3/20/16

9. AGE (last birthday): 45

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

11. BIRTHPLACE (City and state or country): Hopkinsville Ky.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Charlie Catlett

13b. MOTHER'S MAIDEN NAME: Bessie Rudolph

14. NAME OF HUSBAND OR WIFE: Charlie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Sallie Caffery Address: 2230 Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Coronary Sclerosis.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis
DUE TO (c) 420.1
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☒ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 ____ to ____ and last saw her/him alive on ____

Death occurred at 3:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Helen L. Taylor, Coroner

22b. ADDRESS 1300 Clark Ave.

22c. DATE SIGNED 11-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11/25/61

23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cem.

23d. LOCATION (City, town, or county) St. Louis County (State) Mo.

24. FUNERAL DIRECTOR Bannister Mortuary ADDRESS 4251 Washington

25. DATE RECD. BY LOCAL REG. NOV 21 1961

26. REGISTRAR'S SIGNATURE Hoad Smith M.D.

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | DOCUMENT | 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 Leroy H. Lannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.