

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003669

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 29

AMENDED

FILED JAN 11 1962

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANNS HOME</u> | | d. STREET ADDRESS (If outside, give location) <u>5301 PAGE AVE</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE C DIRKERS</u> | | | 4. DATE OF DEATH Month Day Year <u>JAN 1 1962</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 16 1880</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u> | |
| 13a. FATHER'S NAME <u>ALOYSIUS FORST</u> | | 13b. MOTHER'S MAIDEN NAME <u>CATHERINE BOUL</u> | | 14. NAME OF HUSBAND OR WIFE <u>FRANK J DIRKERS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>RAYMOND DIRKERS 2843rd ACCOMAC</u> | | | |

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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) <u>Pneumonia, loban.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>490x</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ | | |
| 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? 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 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 November 1961 to Dec 31, 1961 and last saw her live on Dec 31, 61
Death occurred at 2:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>John J. Costello M.D.</u> (Degree or title) | 22b. ADDRESS <u>2825 Broadway</u> | 22c. DATE SIGNED <u>12-3-62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>JAN 4 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u> |
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| 24. FUNERAL DIRECTOR <u>Thomas Kutsa 2906 Gravois</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>JAN 3 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Paul Smith. M.D.</u> |
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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 *James O. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Davis*

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.