

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048939

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3677 STATE FILE NUMBER

**FILED JAN 10 1963**

VS 300  
Rev. 4/59

1 4031  
2 8040  
3 2  
4 1  
5 2  
6  
7 1  
8 1  
9 330X  
10  
11  
12 43-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>California</u> b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Normandy</u>  |   | Length of stay in 1b<br><u>18 yrs. 9 mos.</u>  | c. CITY OR TOWN <u>Monterey</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST. VINCENT'S HOSPITAL</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>Unknown</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>CATHERINE CHRISTENSEN</u>  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>December 16, 1962</u>  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1/11/88</u>  |
| 9. AGE (last birthday)<br><u>74</u>   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>11</u>   | IF UNDER 24 HR  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Homemaker</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Monterey, California</u>   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |   | 13a. FATHER'S NAME<br><u>Edward Boland</u>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><u>Margaret Kelleher</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Unknown</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>   |   | 16. SOCIAL SECURITY NO.<br><u>none Unknown</u>   |   |
| 17. INFORMANT<br><u>Records of St. Vincent's Hospital</u>   |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, recent extensive</u>  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| DUE TO (b) <u>Rupture of aneurysm of left middle cerebral artery</u>  |   |  |   |
| DUE TO (c)  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Schizophrenic Reaction, Paranoid Type</u> Years   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year   | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20f. CITY, TOWN, OR LOCATION  | COUNTY   | STATE   |
| 21. I attended the deceased from <u>Nov. 1, 1962</u> to <u>Dec. 16, 1962</u> and last saw her <sup>him</sup> alive on <u>Dec. 15, 1962</u><br>Death occurred at <u>1:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE<br><u>Harold D. Wolff, M.D.</u> (Degree or title)  |   | 22b. ADDRESS<br><u>4511 Forest Pk. St. Louis 9, Mo.</u>  | 22c. DATE SIGNED<br><u>12/16/62</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>   | 23b. DATE<br><u>12/18/62</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis Mo.</u>   |
| 24. FUNERAL DIRECTOR<br><u>Cullen Kelly</u>   | ADDRESS<br><u>7267 Natural B ridge</u>  | 25. DATE RECD. BY LOCAL REG.<br><u>12-17-62</u>  | 26. REGISTRAR'S SIGNATURE<br><u>John B. Murphy, M.D.</u>  |

USE BLACK INK OR TYPEWRITER RIBBON

**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 A. Lammers

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.