MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 29019

Township ..... Primary Registration District No. 1003 Registered No. 8602

City St Louis, Mo. (No. 4941 Devonshire St. ..... Ward)

2. FULL NAME Catherine M. Cotner

(a) Residence. No. 4941 Devonshire St., 14 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF ~~MARRIED~~, WIDOWED, OR ~~DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Lee V. Cotner.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27, 1877.

7. AGE: Years 50 | Months 1 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Louisville
(STATE OR COUNTRY) Ky.

PARENTS

10. NAME OF FATHER Herbert Antoine
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) France
12. MAIDEN NAME OF MOTHER Theresa Mackerey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana

14. INFORMANT Mrs Pearl Chalfont
(Address) 4941 Devonshire Av

15. FILED SEP 27 1927, 19 ..... Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 24th 1927

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to Sept 24th 1927, that I last saw her alive on ....., 19..., and that death occurred, on the date stated above, at 7.45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of the Uterus

46 48 93C

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Myocarditis (chronic)

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. ~~DATE OF~~ Inoperable

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Louis A. Brandenburger, M.D.

, 19 (Address) 3922 Cleveland Ave.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Park Lawn Cemetery | DATE OF BURIAL: 9/27/1927

20. UNDERTAKER: Bergesch U. Co. 3661 Washington Pl | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...PERMANENT RECORD