

MAR 14 1939

APR 7 1939

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

12285
Do not use this space.

1. PLACE OF DEATH

(a) County St. LOUIS 2 Registration District No. 784
(b) ~~Township~~ NORMANDY Primary Registration District No. 200
(c) City..... (d) Street No. 7003 Woodrow St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Catherine J. FNER
(a) Residence, No. 7003 Woodrow St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 11, 1861
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.
77 11 11
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home Work
9. Industry or business in which work was done, as saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE Calvary DATE 3-15-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED

MAR 14 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-11 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1929, to March 11, 1939
I last saw h. e. v. alive on March 11, 1939. Death is said to have occurred on the date stated above, at 11:25 p. m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Generalized Arteriosclerosis

Date of onset

Other contributory causes of importance:

Basema of left lower extremity
due to arterial thrombosis
Distraction of Carotid

Name of operation..... none Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred to industrial, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) W. M. Moore, M. D.(Address) 7301 Natural BridgeNormandy, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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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 James A. Lammers,
Registered Apprentice No. 188, working under my personal supervision.

Signed John Fitzgerald
Licensed Embalmer No. 131
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 this body is not embalmed, above space should be left blank.