

Registration District No. **791**
1003

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Katherine White

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas White 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 2, 1869.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 9 18 hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas McGrail

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles J. Dyer

(b) Address 4012 W. Florrisant Ave.,

17. (a) Burial (b) Date thereof 6/22/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John A. Genteman

(b) Address 5077 Durant St.,

19. (a) JUN 21 1939 (b) J. B. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4018a West Florrisant Ave.,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20th
year 1939 hour 8 minute 25 A. M.

21. I hereby certify that I attended the deceased from Monday
13, 1939 to June 20, 1939
that I last saw her alive on June 20, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration _____

Due to _____

Due to _____

Other conditions Aggravated Pulmonary
(Include pregnancy, within months of death)

Major findings: Robert
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature H. E. Mason (M. D. or other) _____

Address 4005 W. Florrisant Date signed 6/22/39

WHILE FLAINLY—USE UNFADING BLACK INK—MAKE 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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.