

Registration District No. 1003 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: City Hospital
(d) Length of stay: In hospital or institution 12 days
In this community UNKNOWN

3. (a) PRINT FULL NAME KATHELEE H. Catherine Parker 626
8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race White
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife UNKNOWN
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased About 1899

8. AGE: Years About 40 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace UNKNOWN

10. Usual occupation UNKNOWN

11. Industry or business UNKNOWN

12. Name UNKNOWN

13. Birthplace UNKNOWN

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN

16. (a) Informant's own signature (FRIEND) Charles Malone

(b) Address 2009 O'FALLON ST. LOUIS, MO.

17. (a) BURIAL (b) Date thereof 7-22-39

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director W. J. Co.

(b) Address 7814 SO. BROADWAY ST. LOUIS, MO.

19. (a) JUL 21 1939 (b) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(d) Street No. 2009 O'FALLON ST.
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 19 day July
year 1939 hour 1:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from 7/8/39
and that death occurred on the date and hour stated above.

that I last saw her alive on 7/19
Immediate cause of death Subchronic Tuberculosis
Due to Syphilis
Other conditions Salpingitis
Major findings: Of operations _____
Of autopsy Chad case

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____
28. Signature W. J. Co. (M. D. or other) _____
Address City Hospital Date signed 7/20/39

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.

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Brown*

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.