

FILED SEP 21 1943 318

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8169**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)
In this community Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5530 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Katherine H. Van Norstrand

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

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

7. Birth date of deceased Sept. 24 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 17 hr. min.

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

10. Usual occupation School Teacher

11. Industry or business Public Schools

MOTHER { 12. Name Jacob Van Norstrand

13. Birthplace Plainfield N. J.
(City, town, or county) (State or foreign country)

14. Maiden name Frances H. Post
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Frances P. Learned

(b) Address New London, Conn.

17. (a) Burial (b) Date thereof 9 14 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Wagoner Und. Co.

(b) Address 3621 Olive Street

19. (a) SEP 14 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10
year 1943 hour 10 minute 22 P.M.

21. I hereby certify that I attended the deceased from Sept. 10, 1943, to Sept. 12, 1943
that I last saw her alive on Sept. 12, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction
Duration _____

Due to _____

Due to 9 H.A.

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy myocardial infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, 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) (e) Means of injury _____

23. Signature A.C. Adams (M. D. or other) _____

Address BARNES HOSPITAL Date signed 9/12/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Melvin L. Keuper

Licensed Embalmer No. 4052

P. O. Address 4005 Lexington Ave

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, fact should be so stated above.