

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 24 1946
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **15045**
Registrar's No. **3530**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3549 Itaska
(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 Mullich**

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 **Widow**

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

7. Birth date of deceased **Sept. 29 1868**
(Month) (Day) (Year)

8. AGE: Years **77** Months **6** Days **16** If less than one day hr. _____ min. _____

9. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Sebastian Kaufmann**

13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Warren W. Pollock**

(b) Address **4816 Milentz**

17. (a) **Burial** (b) Date thereof **4/18/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **O. SS. Peter & Paul**

18. (a) Signature of funeral director **Wacker-Idolule**

(b) Address **3634 Gravois Ave.**

19. (a) **APR 17 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **2-17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4816 Milentz** **9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **15**
year **1946** hour **7** minute **50P** M.

21. I hereby certify that I attended the deceased from **March 5**
19**46** to **April 15** 19**46**
that I last saw her alive on **15 April** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Gall Bladder** **7 month**
Duration

Due to _____

Due to _____

Other conditions **Metastases to liver**
(Include pregnancy within 3 months of death) **Hypertensive Head disease**

Major findings **X-rays indicate tumor**

Of operations **Gall Bladder**

Of autopsy _____

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) (e) Means of injury _____

23. Signature **Francis H. Weinel** (M. D. or other) **M.D.**

Address **5205 E. Chippewa** Date signed **4-16-46**

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

13945

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 Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address. Shaw Mo

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.