

3. No. 2
M-5-43
5-17-39
I X38671

Registration District No. **318**

Primary Registration District No. **1003**

State File No. _____
Registrar's No. **79377**

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

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **70 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2203 Dickson** **4190**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Cathey**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **7**
year **1946** hour **2** minute **15 P** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Jeda Cathey** 6. (c) Age of husband or wife if alive **about** years
7. Birth date of deceased **Feb. 10 1892**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **6-28** 19 **46** to **9-7** 19 **46**
that I last saw him alive on **Sept. 7** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Massive Splenic Infarction (Etiology not clear)**
Bronchogenic Carcinoma - Bilateral

8. AGE: Years **64** Months **6** Days **27**
If less than one day hr. _____ min. _____

Due to _____
Due to _____
Other conditions **None**
(Include pregnancy within 3 months of death) **47**

MOTHER FATHER

9. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**
10. Usual occupation **Lab au**
11. Industry or business _____
12. Name **Willie Mathew Cathey** **9**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country) **9**

Major findings: _____
Of operations _____
Of autopsy **Yes**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Irma Davis**
(b) Address **222 A. Miller St**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-13-46**
(Month) (Day) (Year)
(c) Place: burial or cremation **Oakdale Cemetery**
18. (a) Signature of funeral director **[Signature]**
(b) Address **2197 of Fayette**
19. (a) **SEP 17 1946** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

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) Means of injury **0**
23. Signature **E. B. Williams** (M. D. or other) **0**
Address **2601 N Whittier** Date signed **9/17/46**

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.....

Licensed Embalmer No.....

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, fact should be so stated above.