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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
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318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34936

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9017

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:
St. Louis City Hospital-Max C. Starkloff
 (If not in hospital or institution, write street number or location) **Memorial**
 (d) Length of stay: In hospital or institution **25 days**
 (Specify whether
 In this community **32 years**
 years, months or days)

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. **Park Hotel-13th & Olive Sts.;**
 (If rural, give location) **9**
 (e) Citizen of foreign country? **no** (Yes or No) **0**
 If yes, name country.....

3. (a) PRINT FULL NAME **CATHERINE BIRCHFIELD**
 3. (b) If veteran, name war **---**
 3. (c) Social Security No. **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **18th**
 year **1946** hour **8:00** minute **A** M.
 21. I hereby certify that I attended the deceased from **9/23/46**
 to **Oct. 18th 1946**
 that I last saw her alive on **Oct. 18th 1946**
 and that death occurred on the date and hour stated above.

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
Unknown
 7. Birth date of deceased **February 4th, 1888**
 (Month) (Day) (Year)

Immediate cause of death **Carcinoma of cervix**
 Duration
 Due to.....
 Due to.....
 Other conditions:
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
58 8 14
 hr. min.
 9. Birthplace **Pennsylvania**
 (City, town, or county) (State or foreign country)

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

MOTHER FATHER
 10. Usual occupation **Unknown**
 11. Industry or business.....
 12. Name **James Unknown** **9**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Anna Unknown**
 15. Birthplace **Unknown** **9**
 (City, town, or county) (State or foreign country)
 16. (a) Informant **M. Renard**
 (b) Address **1515 Lafayette Ave.**
 17. (a) **Burial** (b) Date thereof **10-22-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Valhalla Cemetery**
 18. (a) Signature of funeral director **Albert H. Hoppe**
 (b) Address **4700 Washington Blvd.**
 19. (a) **OCT 21 1946** (b) **J. F. Brebeck**
 (Date received local registrar) (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) (e) Means of injury.....
 23. Signature **1515 Lafayette 10/19/46**
 (M. D. or other) **Clash**
 Address..... Date signed.....

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.....

J. W. Wilkinson

Licensed Embalmer No.....

3575

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.