

No. 2  
-12-45  
-17-39  
X 47020

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6043**  
Registrar's No. **1305**

FILED FEB 17 1947

318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County ST. LOUIS, MO.

(b) City or town ST. LOUIS, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution ST. LOUIS CITY HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 45 YRS.  
years, months or days

3. (a) PRINT FULL NAME CATHERINE BOTT

3. (b) If veteran, name war =

3. (c) Social Security No. =

4. Sex Fe 1 5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Wm Bott

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased MAY 30 1886  
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace IOWA 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Keffe 9

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name ON KOGAN 9

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Bott

(b) Address 2417 Blair

17. (a) BURIAL (b) Date thereof FEB 10 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Bredsted

(b) Address 1936 St. Louis Ave

19. (a) FEB 8 - 1947 (b) J. F. Bredsted  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County 0-00

(c) City or town ST. LOUIS 2617  
(If outside city or town limits, write "RURAL")

(d) Street No. 2417 BLAIR 9  
(If rural, give location)

(e) Citizen of foreign country? = (Yes or No) 0

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month FEB. day 6th,  
year 1947 hour 10:30 minute A M.

21. I hereby certify that I attended the deceased from 1-16-47  
19\_\_\_\_ to 2-6-47 19\_\_\_\_  
that I last saw her alive on 2-6-47 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Wrenia 3 Days  
Duration

Due to Blockage of Ventrals ?

Due to Carcinoma of Cervix Uteri 2 Year

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

(c) Means of injury \_\_\_\_\_

While at work? \_\_\_\_\_

Signature Francis Kenna (M. D. or other) 0

Address 1515 LAFAYETTE

Date signed 2-6-47

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.....

*Delis J. Krupin*

Licensed Embalmer No.....

*3497*

P. O. Address.....

*1936 St. Louis*

**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.**