

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 1003

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

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)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5141 Cote Brilliante Ave.
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

KATHERINE WAGNER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Age or race white
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
Unknown

7. Birth date of deceased June 26, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 1 2 hr. _____ min.

9. Birthplace Reading, Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Phillip Huber

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

14. Maiden name Martha Unknown

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

16. (a) Informant Mr. Lou Wissler

(b) Address 5141 Cote Brilliante Ave.

17. (a) burial (b) Date thereof 7/29/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion's Cemetery

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) JUL 29 1948 J. F. Breda
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28th
year 1948 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from 7/26/48
_____ 19 _____ to July 28th 19 48

that I last saw her alive on July 28th 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Carcinoma of sigmoid with Intestinal Obstruction

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury NI

23. Signature Albert Repetto M.D. _____
515 Lafayette _____ (Date signed or other)

Address _____ Date signed _____

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 Warren A. Carver

Licensed Embalmer No. 3534

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.