

No. 300  
1-10-47  
1-17-39  
1-21-39

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
**FILED DEC 4 1948**  
Registration District No. 1848

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

**38878**  
State File No. \_\_\_\_\_  
Registrar's No. **2656**

Primary Registration District No. **3066**

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

**1. PLACE OF DEATH:**  
(a) County **ST. LOUIS**  
**Kirkwood, Missouri**  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
**519 Central Place**  
(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** **CATHERINE M. COLVIN**  
**3. (b) If veteran,** \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_  
name war \_\_\_\_\_

**4. Sex** **female** **5. Color or race** **white** **6. (a) Single, widowed, married,** **divorced, widowed**  
**6. (b) Name of husband or wife** **John E. COLVIN** **6. (c) Age of husband or wife if** **dead** years  
**7: Birth date of deceased.** \_\_\_\_\_  
(Month) (Day) (Year)

**8. AGE:** Years **82** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country) **Ireland 4**

**10. Usual occupation** **Housewife**

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

**MOTHER FATHER**  
**12. Name** **Thomas O'Brien**  
**13. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country) **Ireland 4**  
**14. Maiden name** **Mary Clark**  
**15. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country) **Ireland 4**

**16. (a) Informant** **Mrs. Thomas G. Kelly, Daughter**  
**(b) Address** **519 Central Place,**  
**burial** **(b) Date thereof** **11-17-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Int. Calvary Cemetery**

**18. (a) Signature of funeral director** **Sullivan Brothers,**  
**(b) Address** **2849 North Euclid Avenue,**  
**19. (a) 11-12-48** (Date received local registrar) \_\_\_\_\_  
(Registrar's signature) \_\_\_\_\_

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Kirkwood 96**  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL") **4**  
**(d) Street No.** **519 Central Place**  
(If rural, give location) **3**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **November**, day **14th**  
year **1948** hour **8:20 P.M.** minute \_\_\_\_\_  
**21. I hereby certify that I attended the deceased from** **Sept 3**  
\_\_\_\_\_, 19\_\_\_\_, to **Nov. 14**, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

**Immediate cause of death** **Arterio Sclerotic Heart Disease**  
**Due to** \_\_\_\_\_  
**Due to** **Arterio Sclerosis**  
**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

**Major findings:**  
Of operations \_\_\_\_\_  
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, or in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
**23. Signature** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
**Address** **1104 N. Adams** Date signed \_\_\_\_\_

Mr. J. D. Staelzle  
102 W. Adams  
Ki. 1200

---

---

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 L. Bombauer  
Licensed Embalmer No. 3553

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.**

Registration District No. 317

Primary Registration District No. 3066

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Catherine M. Colovin

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced Wid

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years about 82 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ m.

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

38878