

FILED AUG 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28743**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3063** Registrar's No. **1852**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY MO.	
b. CITY OR TOWN Clayton	c. LENGTH OF STAY (in this place) 1 1/2	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSPITAL		d. STREET ADDRESS (If rural, give location) 9223 PAVIA AV.	

3. NAME OF DECEASED (Type or Print) KATIE RALSTON	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) July 30, 1949
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5. SEX FEMALE	6. COLOR OR RACE W.	7. MARRIED—NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH FEB. 21-1899	9. AGE (In years last birthday) 59 YRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME BENSON	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE GEORGE RALSTON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME George T. Ralston	ADDRESS 4950 Columbia Av.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis, generalized		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bangrene of small intestine		11 days
	DUE TO (c) Thrombosis of Mesenteric Arteries		11 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic Heart Disease		25 yrs	

19a. DATE OF OPERATION 7-22-49	19b. MAJOR FINDINGS OF OPERATION Bangrene of small intestine	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 578K

22. I hereby certify that I attended the deceased from **7-22**, 19**49**, to **7-30**, 19**49**, that I last saw the deceased alive on **7-30**, 19**49**, and that death occurred at **5:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert H. Zull	(Degree or title) M.D.	23b. ADDRESS 601 Brentwood Clayton Mo.	23c. DATE SIGNED 7-30-49
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24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) BURIAL	24b. DATE AUGUST 2-49	24c. NAME OF CEMETERY OR CREMATORY VAL HALLA CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY Mo
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DATE REC'D BY LOCAL REG. 8-1-49	REGISTRAR'S SIGNATURE Herbert R. Donker	25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmur	ADDRESS 3125 Lafayette Av.
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MAR 11 1963

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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.....

Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Licensed Embalmer No. *410/4*

P. O. Address *3125 Lafayette Ave*

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.