

FILED APR 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11434

4001
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3064 Registrar's No. 745

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Oak Knoll Nursing Home		d. STREET ADDRESS (If rural, give location) 4569a Athlone Ave.	
3. NAME OF DECEASED a. (First) Katherine (Katie) (Type or Print)		b. (Middle) _____ c. (Last) Sutter	
4. DATE OF DEATH March 20, 1950		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH April 3, 1864		9. AGE (In years last birthday) 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Mexico, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Sutter		13b. MOTHER'S MAIDEN NAME Cleophia Steinlaug	
14. NAME OF HUSBAND OR WIFE None		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. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Irene Barco ADDRESS 4122a San Francisco	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Aortic stenosis	
DUE TO (c) Hypertensive + arteriosclerotic Cardio-vascular disease		DUE TO (c) 5 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Rt. hemiplegia old	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) 443X	
21d. TIME OF INJURY _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from Sept 16, 1948 , to March 20, 1950 , that I last saw the deceased alive on March 16, 1950 , and that death occurred at 7:30a m. , from the causes and on the date stated above.	
23a. SIGNATURE Lewis Littmann MD (Degree or title)		23b. ADDRESS 9231 Clayton Rd (17)	
23c. DATE SIGNED 3/21/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 3-22-50		24c. NAME OF CEMETERY OR CREMATORY Elmwood	
24d. LOCATION (City, town, or county) (State) Mexico, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.	
DATE REC'D BY LOCAL REG. 3-21-50		REGISTRAR'S SIGNATURE Albert H. Hoppe MD	

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 Me

working under my personal supervision.

Student Embalmer No.....

Signed Ray W. Wilkinson

Signed.....
Student Embalmer

Licensed Embalmer No. 3575

P. O. Address St. Louis, Mo

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.