

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18799

FILED JUN 9 1950

State File No. 4907
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY OR TOWN <i>ST. LOUIS</i>		b. COUNTY <i>MO 244</i>	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <i>ST. LOUIS 0</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>726 Lynch St</i>		d. STREET ADDRESS (If rural, give location) <i>726 Lynch St</i>	

3. NAME OF DECEASED (Type or Print) <i>KATHERINE</i>	a. (First)	b. (Middle) <i>WORLEY</i>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <i>JUNE 2 - 1950</i>
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5. SEX <i>FE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>Oct. 20 - 1871</i>	9. AGE (In years last birthday) <i>78 YR</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 1 YEAR Days	12. IF UNDER 1 YEAR Hours	13. IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWN</i>	11. BIRTHPLACE (State or foreign country) <i>ST. LOUIS MO. D</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>UNKNOWN SCHNEIDER</i>	13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>CHAS. WORLEY</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <i>William E. Rex</i>	ADDRESS <i>726 Lynch St</i>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocarditis chronic</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>H252</i>
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22. I hereby certify that I attended the deceased from *4/4/50*, 19*50*; to *JUNE*, 19*50*, that I last saw the deceased alive on *JUNE 14, 1950*, and that death occurred at *1:20 A.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>Dr. John B. ...</i>	(Degree or title)	23b. ADDRESS <i>16 25th St Jefferson</i>	23c. DATE SIGNED <i>6-3-50</i>
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24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE <i>JUNE-5-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St. MATTHEW'S Cem</i>	24d. LOCATION (City, town, or county) (State) <i>St. LOUIS MO</i>
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DATE REC'D BY LOCAL REG. <i>JUN 4 1950</i>	REGISTRAR'S SIGNATURE <i>J. B. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. ...</i>	ADDRESS <i>3125 Lafayette av</i>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Joseph B. Vollmer

Signed.....
Student Embalmer

Licensed Embalmer No. 4014

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.