

FILED FEB 6 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2361

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 892

| | | | |
|-----------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | c. LENGTH OF STAY (in this place) <u>40-yrs.</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2229</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1427 Chouteau Ave.</u> | | 2. STREET ADDRESS (If rural, give location) <u>1427 Chouteau Ave.</u> | |

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|---------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------|---------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Katherine</u> b. (Middle) c. (Last) <u>Birkner</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 27, 1951</u> | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W. 2</u> | 8. DATE OF BIRTH <u>Nov. 28, 1874</u> | 9. AGE (In years last birthday) <u>76</u> | <u>1</u> YEAR <u>29</u> MONTHS <u>1</u> DAY |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Evansville, Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |

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|--------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| 13a. FATHER'S NAME <u>Jacob Girard</u> | | 13b. MOTHER'S MAIDEN NAME <u>Eva R. Kell</u> | | 14. NAME OF HUSBAND OR WIFE <u>John Birkner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Leo Birkner, 4047 Cleveland Ave.</u> | |

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | DUE TO (b) <u>Cerebral Apoplexy</u> | | | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 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 checked="" 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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>334X</u> | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:00 P. m., from the causes and on the date stated above.

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|-------------------------------------------------------------|--|--------------------------------|--|---------------------------------------------------------------------|--|
| 23a. SIGNATURE <u>Joseph M. ...</u> (Degree or title) | | 23b. ADDRESS <u>1300 Clark</u> | | 23c. DATE SIGNED <u>1/29/51</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial (1)</u> | | 24b. DATE <u>Jan. 31, 1951</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Rosita Cemetery</u> | |
| | | | | 24d. LOCATION (City, town, or county) (State) <u>St. James, Mo.</u> | |

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|---------------------------------------------|--|----------------------------------------|--|--------------------------------------------------------------------------------------|--|
| DATE REC'D BY LOCAL REG. <u>JAN 29 1951</u> | | REGISTRAR'S SIGNATURE <u>J. B. ...</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly, 40 Lindell Blvd.</u> | |
|---------------------------------------------|--|----------------------------------------|--|--------------------------------------------------------------------------------------|--|

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

[Handwritten signature]

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.....

W. VanMatre

Signed.....
Student Embalmer

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

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.