

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32991**
Registrar's No. **7866**

FILED SEP 24 1953

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 MISSOURI b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		2109 0
d. FULL NAME OF HOSPITAL OR INSTITUTION DEPAUL HOSPITAL			d. STREET ADDRESS (If rural, give location) 4111 ASHLAND AVE		
3. NAME OF DECEASED (Type or Print) a. (First) KATHRYN		b. (Middle) T.	c. (Last) CAREY	4. DATE OF DEATH (Month) (Day) (Year) AUG, 10, 1953	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 12/29/1886	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME MICHAEL M NICHOLSON		13b. MOTHER'S MAIDEN NAME MARGARET KELLY	14. NAME OF HUSBAND OR WIFE RICHARD J. CAREY		
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. #	17. INFORMANT'S SIGNATURE OR NAME MRS ROY CHANDLER ADDRESS 4111 ASHLAND AVE		
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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 7/10.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hypertension & arteriosclerosis				
	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 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) H20.0		
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?		
22. I hereby certify that I attended the deceased from Aug 5, 1953 , to Aug 10, 1953 , that I last saw the deceased alive on Aug 11, 1953 , and that death occurred at 10 P. M. , from the causes and on the date stated above.					
23a. SIGNATURE D. J. Gorman M.D. (Degree or title)		23b. ADDRESS 539 N. Howard St. St. Louis		23c. DATE SIGNED 8/11/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8/13/53	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 11 1953		REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE STROUT - CARROLL ADDRESS 1600 NATURAL BRIDGE AVE		

WRITE PLAINLY—USING UNFADING BLACK INK—MADE IN U.S.A.

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.

Student
Student Embalmer

Signed M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.