

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27495

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6818**

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) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. City Hospital		e. STREET ADDRESS (If rural, give location) 4225 Randall Place 20970	
3. NAME OF DECEASED (Type or Print) a. (First) KATHERINE b. (Middle) BUETTERHORN c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) August 3, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 19, 1865
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home,		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Emge		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE widowed			
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. Anna Fels, 1509 Farragut St.		ADDRESS	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestine Obstruction ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. QUE TO (b) Senility, Incess 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 5705	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)			
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?			
22. I hereby certify that I attended the deceased from Jan 1955 , to 8/3, 1955 , that I last saw the deceased alive on 8-3, 1955 , and that death occurred at 11 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE A. D. Fels		23b. ADDRESS 2503 No. Thompson	
23c. DATE SIGNED 8-5-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 6, 1955	
24c. NAME OF CEMETERY OR CREMATORY Friednes Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. AUG 5 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Stock Mortuaries, 2117 E. Grand		ADDRESS	

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

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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..

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Washburn*

Licensed Embalmer No. *478*

P. O. Address *Howe*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.