

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28423
State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 1993

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY OR TOWN <u>Kirkwood</u>	c. LENGTH OF STAY (in this place) <u>18 Mo.</u>	c. CITY OR TOWN <u>St. Louis</u>	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 <u>St. Agnes Home</u> <u>1031 1/2 Manchester</u>		STREET ADDRESS (If rural, give location) <u>4497 Pershing Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) Katherine b. (Middle) _____ c. (Last) Walsh

4. DATE OF DEATH (Month) (Day) (Year) Aug., 25, 1955

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH April 15, 1875 9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months 4 IF UNDER 12 HRS. Hours 10 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (City and State or Foreign Country) Ireland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Walsh 13b. MOTHER'S MAIDEN NAME Ann Philbin 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) _____ 16. SOCIAL SECURITY NO. NONE 17. INFORMANT'S SIGNATURE OR NAME Miss Agnes Scholz ADDRESS 4497 Pershing Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Pericardial Fibriation

ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) supraventricular Heart Disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Post cerebral Hemorrhage

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION 4222 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan 1953, to Aug 25, 1955, that I last saw the deceased alive on Aug 4, 1953, and that death occurred at 11:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. J. Volkmann 23b. ADDRESS 53 W. Big Bend 23c. DATE SIGNED 8/26/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Aug. 27, 55. 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. 8/26/55 REGISTRAR'S SIGNATURE Herbert R. Dombke M.D. 25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly ADDRESS 3840 Lindell Blvd.

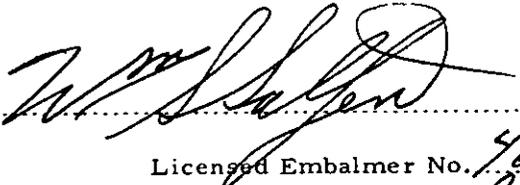
S.C. (Licensed Embalmer's Statement on Reverse Side)

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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 469

P. O. Address 3840 Linden

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.