

FILED OCT 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31725

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 541		Registrar's No. 2207			
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, write RURAL and give township) <b>Clayton</b>		c. LENGTH OF STAY (in this place) <b>D.O.A.</b>		c. CITY OR TOWN <b>Florissant</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>				STREET ADDRESS (If rural, give location) <b>Rt 1 Box 187 Florissant Mo.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Catherine</b>			b. (Middle) <b>Virginia</b>		c. (Last) <b>Braun</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 21, 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 13 1914</b>	9. AGE (In years last birthday) <b>41</b>	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) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Thomas Mulvihill</b>			13b. MOTHER'S MAIDEN NAME <b>Frances Gardiner</b>		14. NAME OF HUSBAND OR WIFE <b>Anthony Braun</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Anthony Braun Rt 1 Box 187 Florissant</b>					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cognitive Heart Failure</b> ANTECEDENT CAUSES <b>Rheumatic Heart Disease</b> Morbidity 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.				INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>401-4116 X</b>				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)					
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 <b>April 15, 1955</b> , to <b>April 21, 1955</b> , that I last saw the deceased alive on <b>April 15, 1955</b> , and that death occurred at <b>6:00 a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>N. B. Javan M.D.</b>				23b. ADDRESS <b>539 N. Grand St. St. Louis</b>		23c. DATE SIGNED <b>9/23/55</b>			
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE <b>Sept 23 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>			
DATE REC'D BY <b>9/22/55</b>		REGISTRAR'S SIGNATURE <b>W. H. ...</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Allier Mortuary 10123 St. Charles Rd.</b>					

WRITE PLAINLY - USUALLY

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... Sheldon Collins

Licensed Embalmer No. 3

P. O. Address 1012387

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.