

Health, Welfare, Public Service
 000-56
 AN
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

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 STATE FILE NUMBER 711

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BETHESDA Hosp.</i>		Length of stay in lb	STREET ADDRESS <i>2167 3205 ARSENAL</i>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>CATHERINE</i> Middle <i>BACIK</i> Last			4. DATE OF DEATH Month <i>JAN.</i> Day <i>21</i> Year <i>1957</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT 27 1877</i>	9. AGE (In years last birthday) <i>79</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WIDOW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (City and state or country) <i>ST. LOUIS Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>HENRY SUEDKAMP</i>			14. MOTHER'S MAIDEN NAME <i>CHRISTINE OSTMANN</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>MARGARET BACIK</i> Address <i>3205 ARSENAL</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion with infarct</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arterio-sclerotic cardio-vascular disease</i> DUE TO (c) <i>Diabetes mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>26 Dec. 1956</i>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour <i>1.30 P</i> Month <i>Dec.</i> Day <i>26</i> Year <i>1956</i> a. m. p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <i>26 Dec. 1956</i> to <i>21 Jan. 1957</i> and last saw her alive on <i>20 Jan. 1957</i> . Death occurred at <i>1.30 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert L. Nye, M.D.</i> (Degree or title)			22b. ADDRESS <i>3201 Arsenal St., St. Louis Mo</i>		22c. DATE SIGNED <i>22 Jan 1957</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>JAN 24 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>RESURRECTION CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS CO. Mo</i>
24. FUNERAL DIRECTOR <i>Thomas Kuter 2906 Gravois</i>		ADDRESS	25. DATE RECD. BY LOCAL REG. <i>JAN 23 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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12-3 Tue
1900-2754

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 39

P. O. Address.....
St. Louis

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.