Health, Welfare Public Service

300
1-56

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26080
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6253

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, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hosp — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 7957 Frederick Ave — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First: Catherine	Middle: A	Last: Fabian	4. DATE OF DEATH Month Day Year: July 4 1957
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Apr 15 1914	9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): St.Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Patrick Meehan		14. MOTHER'S MAIDEN NAME: Mary Griffin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 488 07 8787	17. INFORMANT: Walter Fabian	Address: 7957 Frederick Ave	

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Laennec's Cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH: 6 mos. at least

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 581.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 June 29, 1957 to July 4, 1957 and last saw her alive on July 3, 1957. Death occurred at 10 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sylvester A. Feotte M.D.

22b. ADDRESS: 8700 Riverview Blvd.

22c. DATE SIGNED: 7-5-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: July 8 57

23c. NAME OF CEMETERY OR CREMATORY: Calvary

23d. LOCATION (City, town, or county) (State): St.Louis Mo

24. FUNERAL DIRECTOR: E.J.Schnur — ADDRESS: 3125 Lafayette

25. DATE RECD. BY LOCAL REG.: JUL 5 '57

26. REGISTRAR'S SIGNATURE: J Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Thomas R. Lenwick

Licensed Embalmer No. 37

P. O. Address 3125 Lof

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.