

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 18 1960

211987 - 59-047065 STATE FILE NUMBER

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 <u>Mo</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>AFFTON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>9501 SEQUOIA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE WITBRODT</u>			4. DATE OF DEATH <u>DEC. 25 1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 18 1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>		13a. FATHER'S NAME <u>BERNARD WITBRODT</u>		13b. MOTHER'S MAIDEN NAME <u>MARY AHRENHORSTERBAUMER</u>	
14. NAME OF HUSBAND OR WIFE <u>JOHN WITBRODT</u>		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. <u>NONE</u>	
17. INFORMANT <u>RUTH DEHNE</u>		18. ADDRESS <u>AFFTON Mo</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Thrombosis of lt. vent. strate art</u>		<u>7 weeks</u>
DUE TO (b) <u>Cerebro-vascular arterio sclerosis</u>		<u>years?</u>
DUE TO (c) <u>332x</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <u>no no no</u>	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 <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 11-4-59 to 12-25-59 and last saw her alive on 12-25-59  
Death occurred at 2 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John J. Hammond M.A.</u>		22b. ADDRESS <u>634 N. Grand</u>		22c. DATE SIGNED <u>12/27/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL DEC. 28 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CHURCHYARD</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. FUMERAL DIRECTOR <u>Thomas Hutes 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 28 1959</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u> <u>m. g. 13-</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*180-  
Kurtis*

*will telephone is*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *James C. Hill*

Licensed Embalmer No. *4347*

P. O. Address *2916 Du*

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