

FEB 12 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1288  
Do not use this space.  
1144

791  
1003

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. ....  
(c) City St. Louis (d) Street No. Park Lane Memorial Hospital St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kate Morey 600

(a) Residence, No. RFD. #9 Yaeger Rd. St. [MP] Lemay, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Arthur S.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16, 1884

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
<u>53</u>	<u>8</u>	<u>13</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

13. NAME M. Graham

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

15. MAIDEN NAME Kate Colt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 29 19 38

22. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1938, to Jan 29, 1938  
I last saw her alive on Jan 29, 1938. Death is said to have occurred on the date stated above, at 8.30 P.M.  
The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis  
Acute Dil. Heart  
Date of onset

Other contributory causes of importance:  
Chronic Myocarditis

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? .....  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify .....  
(Signed) [Signature], M. D.  
(Address) 4830 Lindell Blvd

17. INFORMANT Jessie Morey  
(ADDRESS) RFD. #9 Lemay, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Park Hill Cem. DATE Feb. 1 19 38

19. FUNERAL DIRECTOR C. Hoffmeister U. & L. Co.  
(ADDRESS) 7814 S. Broadway

20. FILED JAN 31 1938 [Signature]  
Local Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, George W. Hoffmeister, Licensed Embalmer No. 2426

hereby certify that the body recorded on the reverse side of this certificate was embalmed by L. C. Hoffmeister # 3871

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Geo. W. Hoffmeister  
Licensed Embalmer 2426 2426

**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.)**