

MAY 15 1940

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1500 Gregg Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
(Specify whether  
In this community  
years, months or days)

3. (a) PRINT FULL NAME Jane Morkoetter 623

8. (b) If veteran, name war 3. (c) Social Security No. none

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Christian Morkoetter 6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 24, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 11 29 hr. min.

9. Birthplace County Cork Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

12. Name UNKNOWN

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant William Morkoetter (son)

(b) Address 1500 Gregg Ave.

17. (a) Burial (b) Date thereof Apr. 25, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M. J. Creghan

(b) Address 7146 Manchester Ave.

19. (a) APR 23 1940  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1500 Gregg Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 23  
year 1940 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from April 22  
1940, to April 23, 1940  
that I last saw her alive on April 22, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage

Due to Arteriosclerosis

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? (e) Means of injury

23. Signature Foster A. Dill (M. D. or other) M.D.  
Address 7346a Manchester Date signed 4/23/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Francis A. Williamson*

Licensed Embalmer No. 3565

P. O. Address 7146 Manchester Ave,

**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.)**

**If this body is not embalmed, above space should be left blank.**