

Registration District No. **318**

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:  
**Firmin Desloge Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3002 St. Louis Ave**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Catherine Grady**

3. (b) If veteran, name war. No. 3. (c) Social Security No.

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

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

7. Birth date of deceased **August 8 1892**  
(Month) (Day) (Year)

8. AGE: Years **50** Months **6** Days **22** If less than one day hr. min.

9. Birthplace **BUNKER HILL Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business

MOTHER FATHER  
12. Name **STEPHEN GRADY**  
13. Birthplace **IRELAND**  
(City, town, or county) (State or foreign country)  
14. Maiden name **MARY ANN MOFFITT**  
15. Birthplace **IRELAND**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Jean Keitle**

(b) Address **ALTON, ILL**

17. (a) **BURIAL** (b) Date thereof **3/11/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ALTON, ILL**

18. (a) Signature of funeral director **ALBERT H. HOPPE INC**

(b) Address **4700 WASHINGTON BLVD**

19. (a) **1943** (b) **J. F. Bradick**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **28**  
year **1943** hour **11** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Dec. 14** 19 **42** to **Feb. 28** 19 **43**;  
that I last saw her alive on **Feb. 28** 19 **43**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Leiomyosarcoma of uterus**  
**Plus regional metastases**

Due to **12 hrs.**

Due to **11**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **As above**

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?

While at work (Specify type of place) (c) Means of injury

23. Signature **John P. Ferguson M.D.** (M. D. or other)

Address **1325 S. Grand St. St. Louis** Date signed **3/11/43**

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

**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 *Gay W. Wilkerson*  
Licensed Embalmer No. *3575*

P. O. Address.....

**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, fact should be so stated above.**