

**FILED MAY 26 1945**

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4364

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4160 McPherson  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....

(c) City or town..... St. Louis, Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 4160 McPherson  
(If rural, give location)

(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME..... Katie Moss Radford.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1945 hour 4 minute P. M.

4. Sex..... Female 5. Color or race..... White

6. (a) Single, widowed, married, divorced..... Divorced

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

7. Birth date of deceased..... April 17 1905  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 4, 1945 to May 16, 1945 that I last saw her alive on May 16 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

40 0 29 hr. min.

Immediate cause of death..... Chronic Hypertensive Cardiac Vascular Renal disease

Due to..... 1st

Due to..... old healed Pul. TB

Other conditions.....  
(Include pregnancy within 3 months of death)

9. Birthplace..... Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Nil.

PHYSICIAN

Major findings:  
Of operations.....  
Of autopsy.....

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name..... James Moss.

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

14. Maiden name..... Martha Lewis.

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

16. (a) Informant..... Sally Worley.  
(b) Address..... 4160 Mc Pherson.

17. (a) Removal. (b) Date thereof..... May 19 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Mill Springs, Mo.

18. (a) Signature of funeral director..... Edith E. Ambruster.  
(b) Address..... 4234 Manchester.

19. (a) MAY 17 1945 J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

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?..... (c) Means of injury.....

23. Signature..... R. H. Ehrlich, M.D. (M.D. or other)  
Address: 3606 Grand Date signed: May 16, 45

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

06  
17  
9

MOTHER FATHER

Duration of disease

Ehrlich  
St Louis 16 mo.

**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 \_\_\_\_\_

*Glenn Eymck*

Licensed Embalmer No. \_\_\_\_\_

*1284*

P. O. Address \_\_\_\_\_

*St. Louis, Mo*

**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.**