S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25754

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7828

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: St. John's 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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison

(c) City or town Alton
(If outside city or town limits, write "RURAL")

(d) Street No. 816 Arch St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Catherine M. Heraty

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Leo Heraty

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March (Month) 13 (Day) 1900 (Year)

8. AGE: Years 45 Months 5 Days 22 If less than one day hr. min.

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

10. Usual occupation Bookkeeper

11. Industry or business

FATHER
12. Name Thomas B. March
13. Birthplace Greene County (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Catherine Jennings
15. Birthplace Greene County (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Leo Heraty
(b) Address 816 Arch St., Alton, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Carrollton, Ill

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) SEP 6 1945 (Date received local registrar) (b) J. Medeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 year 1945 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from July 5, 1945, to Sep 5, 1945; that I last saw her alive on Sep 5, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	3 days
Uremia	3 days
Due to Hypostatic pneumonia	1 wk
Toxemia	
Due to Melano-Sarcoma with Metastases	6 mon

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 46

Of autopsy Melanoma involvement of kidneys Liver & Lungs Spleen

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 [signature] (M. D. or other) MD

Address 4952 Maryland Date signed 9/6/45

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Koppe

Licensed Embalmer No. 2971

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.