

Registration District No. **318** Primary Registration District No. **1003**

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:  
**Little Sisters of Poor 5**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. **3 Yrs., 8 Mo.**  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **Catherine Segerson**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **S.**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Feb. 11th., 1869**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **6** Days **12** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Washington D.C. /**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **James Segerson**  
 13. Birthplace **Ireland 4**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Mary Sullivan**  
(City, town, or county) (State or foreign country)  
 15. Birthplace **Ireland 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Sister Jeane**

(b) Address **3225 N. Florissant Ave.**

17. (a) **Burial** (b) Date thereof **8-27-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Kennedy**

(b) Address **3840 Lindell Blvd.**

19. (a) **AUG 25 1945** (b) \_\_\_\_\_  
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo.** (b) County **000**  
 (c) City or town **St. Louis 17**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **3225 N. Florissant Ave. 970**  
(If rural, give location)  
 (e) Citizen of foreign country? **0**  
(Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **23rd.**, year **1945** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **February 12, 1945** to **August 23, 1945**  
 that I last saw her alive on **August 22, 1945**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **???**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **None 93d**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **None**

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) **None**

(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 job) \_\_\_\_\_  
 (e) Means of injury \_\_\_\_\_

23. Signature **Bernard J. Hoffe** (M. D. or other) \_\_\_\_\_

Address **3302 Calvary St.** Date signed **8-24-45**

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

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 17  
 9

**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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Lindell

**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.**