

**FILED** JAN 5 1948  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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

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:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether

In this community \_\_\_\_\_  
year, months or days)

3. (a) PRINT FULL NAME Catherine Fox

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female / 5. Color or race white / 6. (a) Single, widowed, married, divorced, separated

6. (b) Name of husband or wife John Fox 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: April 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>8</u>	<u>0</u>	_____hr. _____min.

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

10. Usual occupation housewife

11. Industry or business none

MOTHER FATHER { 12. Name Michael Morrissey

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Curtis

15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Wilbur J. Fox

(b) Address 1326 N. 20th st

17. (a) Burial (b) Date thereof Dec 24, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. Kron R.L.U. Co.

(b) Address 2707 N. Grand Blv'd

19. (a) DEC 21 1945 (b) J. Medek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
Missouri

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. 5341 Patton  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19  
year 1945 hour 2 minute D M.

21. I hereby certify that I attended the deceased from 12-13-  
1945 to 12-19- 1945  
that I last saw him alive on 12-19- 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Hepatitis  
Cholelithiasis non-calculus  
Anemia (type undetermined)

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

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

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?  
\_\_\_\_\_

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

23. Signature J. F. Eller (M. D. or other) MD

Address 2807 N. Grand Date signed Dec 20 1945

**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     *Jos. E. McCulloch*      
Licensed Embalmer No.     *2460*      
P. O. Address     *6175 Delmar*    

**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.**