

U. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
I X36871

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
FILED MAR 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. 11465

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2460

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

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. 6750 Nashville  
(If rural, give location)  
(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME Christine Morgan  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Feb. 25, 1895  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51 0 17 hr. min.

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

10. Usual occupation Office Manger

11. Industry or business.....

12. Name Albert Schlereth

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

14. Maiden name Unknown

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

16. (a) Informant Dorothy Morgan

(b) Address 6750 Nashville

17. (a) Burial (b) Date thereof 3/12/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4234 Manchester

19. (a) MAR 14 1946 (Date received local registrar)  
J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar days 12  
year 1946 hour 8.15 P. M<sup>i</sup> minute..... M.  
21. I hereby certify that I attended the deceased from 12-3-45  
....., 19....., to 3-12-46....., 19.....  
that I last saw her er alive on 3-12-46....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Myocardial Failure

Due to Hypertensive Cardiovascular Renal Disease. Gall Stones

Due to.....  
Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations None

Of autopsy Findings the same

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)  
Means of injury.....  
23. Signature Edwin Schisler (M. D. or other)  
Edwin Schisler, M.D., F.A.C.P.  
Address 643 Missouri Bldg. Date signed 3-13-46

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
10377

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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.....

*Floring Eynck*

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.**