

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

FILED JUL 3 1948  
Registration District No. 818

Primary Registration District No. 1003

State File No. 5720  
Registrar's No.

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:  
4162a Lee Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 60 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4162a Lee Avenue  
10 (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT GERTRUDE MORGEN  
FULL NAME  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 23d  
year 1948 hour 9 minute 35 P. M.  
21. I hereby certify that I attended the deceased from May 2/48  
to June 23/48, 19\_\_\_\_, to June 23/48, 19\_\_\_\_;  
that I last saw her alive on June 22 48, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Herman Morgen  
6. (c) Age of husband or wife if alive 87 years  
7. Birth date of deceased February 28, 1862  
(Month) (Day) (Year)

Immediate cause of death Portul Cerebros of Brain  
by perforation  
Duration 1 1/2 hrs  
1 1/2 hrs

8. AGE: Years 86 Months 3 Days 25  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 1/2 hr  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation At home

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

MOTHER FATHER  
12. Name Martin Haselhorst  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Brockelman  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Anna McCarthy  
(b) Address 4162a Lee Avenue

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 6-26-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 2117 E. Grand Blvd.

23. Signature J. F. Bredeck (M. D. or other) \_\_\_\_\_  
Address 1825 Madison Date signed 6/24/48

19. (a) JUN 25 1948 (b) \_\_\_\_\_  
(Date of local registrar) (Registrar's signature)

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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 *Frank A. Moore*.....

Licensed Embalmer No. *3041*.....

P. O. Address. *2117 E. Grand*.....

**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.**