

FILED SEP 11 1943  
Registration District No. 818

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Helen Morse

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Late William Morse

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

7. Birth date of deceased Jan. 11th 1896  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation Secretary Red Cross

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

12. Name Oscar F. Wagner

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

14. Maiden name Meta Haacke

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

16. (a) Informant Hugh K. Wagner

(b) Address 3504 Humphrey St.

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof 9-2-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuar

(b) Address 4228 So. Kingshighway Blvd.

19. (a) AUG 30 1943  
(Date received local registrar)

(b) J. F. Buebeck  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 17

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

(d) Street No. 3504 Humphrey St.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29th  
year 1943 hour 7:30 minute A.M.

21. I hereby certify that I attended the deceased from 8-29 1943 to 12-17-43  
that I last saw her alive on 8-28 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Embolism Coronary occlusion

Due to Interup fibroid

Due to No Malignancy

Other conditions Opie R. x atrophy left Ovary

Major findings: Interup fibroid  
Opie R. x atrophy left Ovary

Of autopsy None

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? \_\_\_\_\_

23. While at work? \_\_\_\_\_  
(Specify type of glare)

(a) Degree of injury \_\_\_\_\_

24. Signature George S. McKean  
(M. D. or other)

Address 39630 ewe Date signed 8-29-43

Duration 30 min

PHYSICIAN

Underline the cause to which death would be charged statistically.

3905 Olive St. W. 3-10 P.M.  
No. 2605  
25600

**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 *Richard W. Steveson*

Licensed Embalmer No. *4007*

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.**