

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

**FILED OCT 7 1946**

State File No. \_\_\_\_\_  
Registrar's No. **8302**

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

**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. Johns Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 DAY in hospital or institution  
(Specify whether)

In this community 1 DAY  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Carter

(c) City or town Ellington  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 1  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Wena Hall

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 married

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Mar 25 1895  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 9-25-46 day \_\_\_\_\_  
year \_\_\_\_\_ hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from 9-25-46  
19-25-46, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. her alive on 9-25-46, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia

Due to Head infection  
slight injury

Due to ill

Other conditions (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.

**8. AGE:** Years 51 Months 6 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Webster County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Ch. Morrison

**MOTHER** { 12. Name Ebb Morrison

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

14. Maiden name Sarah Wright

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

16. (a) Informant W. Hall

(b) Address Ellington Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Ellington Mo

18. (a) Signature of funeral director Kenel Funeral Home

(b) Address Van Buren Mo

19. (a) SEP 27 1946 (Date received local registrar)

J. F. Bredeek (Registrar's signature)

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. Signature W. J. Gally (Specify type of place) \_\_\_\_\_  
while at work? (c) Means of injury \_\_\_\_\_

Address 34 N. Grand Date signed \_\_\_\_\_

9-26-46

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

30627

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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.....

*John Ketter ?*

Licensed Embalmer No. *3880*

P. O. Address..... *St Louis 8 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.**