

Registration District No. 318 Primary Registration District No. 1003

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:
Homer G Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 months
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Clara Morning

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race Col
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Dennis Morning
 6. (c) Age of husband or wife if alive Unk years
 7. Birth date of deceased.....
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt 47 - - - - - hr. min.

9. Birthplace Arkansas
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housework

11. Industry or business.....
 12. Name Will McHenry
 13. Birthplace Sallie Guyton
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace.....
 (City, town, or county) (State or foreign country)

16. (a) Informant W. J. McHenry
 (b) Address 2645 Scott Ave 1-3-47
 17. (a) Greenwood Cem (b) Date thereof 1-3-47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director J. F. Bredbeck
 (b) Address 2715 Franklin Ave
 19. (a) JAN 5 - 1947 (b) J. F. Bredbeck
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2645 Scott
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29
 year 1946 hour 10 minute 35 A.M.

21. I hereby certify that I attended the deceased from 9-22, 19 46, 12-29, 19 46
 that I last saw her alive on Dec. 29, 19 46
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 8 days

Due to.....
 Due to..... 107

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

Major findings:
 Of operations.....
 Of autopsy Yes
 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?
 (Specify type of place) (e) Means of injury.....

23. Signature E. A. Wagner (M. D. or other)
 Address 2601 N. Webster Date signed 1/3/46

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 *H.A. Green*

Licensed Embalmer No. 2963

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.