

S. No. 2  
-12-45  
5-17-39  
P.1 X47070

**FILED FEB 3 1947**

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

1. PLACE OF DEATH:  
(a) County .....  
(b) City or town **St. Louis, Missouri.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis City Hospital - Max C. Starkloff**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Memorial**  
(Specify whether  
In this community.....  
years, months or days)

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. **1700A Cass Ave.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **MAUDE MORSE**  
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**  
4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **May 18 1875**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **23rd**  
year **1947** hour **4:15** minute **A** M.  
21. I hereby certify that I attended the deceased from **1/10/47**  
....., 19....., to **1/23/47**....., 19.....;  
that I last saw her alive on **1/23/47**....., 19.....;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**71** **7** **5** hr. min.

Immediate cause of death  
**Pulmonary Embolism**  
**Cellulitis of leg ulcer**  
Due to.....  
Due to.....  
Other conditions **Nephrosclerosis**  
(Include pregnancy within 6 months of death)

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **At Home**

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

11. Industry or business  
12. Name **Dont Know**  
13. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Dont Know**  
15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. George Mc. Donald.**  
(b) Address **4958a Tholozan Ave.**  
17. (a) **Burial** (b) Date thereof **1-25-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**  
18. (a) Signature of funeral director **Cullinane Bros.**  
(b) Address **-3320 N. Kingshighway Blyd.**  
19. (a) **J. J. Bredenk**  
(Date received from registrar) (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?  
While at work?..... (Specify type of place) (e) Means of injury **1/23/47**  
23. Signature **W. H. Yette** (M. D. or other).  
Address..... Date signed.....

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

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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..... *Fred Frick* .....

Licensed Embalmer No..... 3186 .....

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.**