FILED AUG 15 1947

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 318 File No. 25871

Township ..... Primary Registration District No. 1003 Registered No. 7259

City St. Louis (No. 3236 Pennsylvania Ave St. ..... Ward)

2. FULL NAME Catherine J Morgan N.R

(a) Residence. No. 2438½ Alabama St., ... Ward. Indianapolis Ind.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~XXXXXXXX~~ Warren A Morgan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 23, 1904

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
43	3	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Own Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) O'Fallon
(STATE ~~OR COUNTRY~~) Illinois

PARENTS

10. NAME OF FATHER Nicholas Hemmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Clair County
(STATE ~~OR COUNTRY~~) Illinois

12. MAIDEN NAME OF MOTHER Catherine Richard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Warren A Morgan
(Address) Indianapolis, Ind.

15. AUG 4 1947 FILED, 19..... J. F. Bredeck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 3, 1947

17. I HEREBY CERTIFY, That I attended deceased from 3-28, 1947, to ~~July~~ Aug 3, 1947 that I last saw her alive on Aug 3, 1947, and that death occurred, on the date stated above, at 5 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma liver (Primary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

46

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5/29/47 Deaconess Hospital St Louis Mo.

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Everett J. Javaux, M.D.

8-4, 1947 (Address) 601 No. Grand Blvd.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: O'Fallon Illinois

DATE OF BURIAL: 8/6/47 19

20. UNDERTAKER: L. M. Wolfersberger

ADDRESS: O'Fallon, Ill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

...THE PLANET, WITH UNFADING INK. THIS IS A PERMANENT RECORD

THIS IS TO CERTIFY THAT THE REMAINS , AS STATED , ON THE FACE OF THIS CERTIFICATE WAS EMBALMED BY MY -SELF

Elton R. Remelius

MO. LICENSE # 4283

404 EAST ADAMS STREET
O)'FALLON , ILLINOIS