LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

3165

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....

Township..... Primary Registration District No. 1003 Registered No. 1155

City St Louis (No. 3120 Clark St.....Ward)

2. FULL NAME Horace Morrow

(a) Residence. No. 3120 Clark Ave St., 7 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF ~~(OR) WIFE OF~~ Julia Morrow

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 1887

7. AGE: Years 37 | Months 1 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 920
(b) General nature of industry, business, or establishment in which employed (or employer) 930
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Julia Morrow
(Address) 3120 Clark Ave

15. FILED....., 19.... Mark Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1—30—1925

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Jan 30, 1925, that I last saw him alive on Jan 29, 1925, and that death occurred, on the date stated above, at 11:50 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aortic insufficiency with myocarditis
(duration) yrs. 4 mos. 20 ds.

CONTRIBUTORY (SECONDARY) Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? St Louis
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) Oral L. McClellan, M. D
, 19 (Address) 3500 N. Pendleton

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park | DATE OF BURIAL 2—2—1925

20. UNDERTAKER N. S. Wade & Son | ADDRESS 1722 Gamble

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... .....St. .....Ward)

2. FULL NAME .....

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

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTORY
(SECONDARY) .....
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.