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

Do not use this space.
2991

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St Louis Mo (No. 1215 St Louis Ave. St. ..... Ward)

File No. L 582
Registered No. L

2. FULL NAME Robert L. Morrison

(a) Residence. No. 1215 St Louis ave St., 26 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 4 - 1927

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none 109 106
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William H Morrison
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Annie Bieser
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Missouri

14. INFORMANT William H. Morrison
(Address) 1215 St Louis ave

15. FILED JAN 17 1927 Max G Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1927, to Jan 17, 1927, that I last saw him alive on Jan 17, 1927, and that death occurred, on the date stated above, at 8, 12 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchitis acute
Non Tubercular
A 100 A
A (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
Secondary (duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH? No. DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John C Greene, M. D
1-17, 1927 (Address) 2504 N 14th St.

*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 Ozora Mo. DATE OF BURIAL Jan 18 1927

20. UNDERTAKER Hy Leidner Und Co ADDRESS 1417 N Market Do

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.

WRITE PLAINLY, WITH UNFADING INK