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

Do not use this space.

22118

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis, Mo. (No. 3147 Pennsylvania Avenue St. Ward)

File No. .....

Registered No. 6293

2. FULL NAME Olivia Morgan

(a) Residence. No. 3147 Pennsylvania Avenue 16 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)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 6, 1898.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	9	5	

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)

(c) Name of employer

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

(STATE OR COUNTRY) Missouri.

PARENTS

10. NAME OF FATHER John Schneider

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

(STATE OR COUNTRY) Missouri.

12. MAIDEN NAME OF MOTHER Anna Burkart

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

(STATE OR COUNTRY) Missouri

14. INFORMANT Anna Schneider

(Address) 3147 Pennsylvania

15. FILED JUN 13 1928 Ray C. Tarlton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11th, 1928.

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to June 11, 1928, that I last saw her alive on June 11, 1928, and that death occurred, on the date stated above, at 10:05 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Embolism

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY) Syphilis

(duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? at Pleasant Green

DID AN OPERATION PRECEDE DEATH? No. DATE OF. —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Jos. Calabek, M.D.

, 19 (Address) 2900 California Ave.

*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	DATE OF BURIAL
New St. Marcus	June 14 1928.
20. UNDERTAKER Wacker-Heldenbrand	ADDRESS 2331 S. Broadway

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—THIS IS A PERMANENT RECORD