

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

Do not use this space.

22370

**1. PLACE OF DEATH**

County..... Registration District No. **701**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis Mo.** (No. **Barnes Hospital**) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. \_\_\_\_\_ Registered No. **6559**

**2. FULL NAME** *Lea Virginia Morgan*

(a) Residence No. **1401 John St.** St. **9** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. (If MARRIED, WIDOWED OR DIVORCED) *WIDOWED*  
 (OR) WIFE OF *Samuel F. Morgan*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 14 1877*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*51 3 6*

**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) *930*  
 (c) Name of employer *931*

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

10. NAME OF FATHER *E. L. Burns*

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

12. MAIDEN NAME OF MOTHER *Abbie Christian*

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

14. INFORMANT *Wm H. Morgan*  
 (Address) *2401 John*

15. FILED *22 1928*  
 REGISTRAR *Max C. Parkley*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-20-1928*

17. I HEREBY CERTIFY, That I attended deceased from *6-20-1928*, to *6-20-1928*, that I last saw him alive on *6-20-1928*, and that death occurred, on the date stated above, at *2:30 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Muscular Atrophy - Decompensation,  
 Alcoholic Pericarditis,  
 Pericardial Effusion.*

CONTRIBUTORY (SECONDARY) *Pneumonia Broncho*  
 (duration) *2 yrs. 6 mos. da.*  
*931* (duration) *2 mos. da.*

18. WHERE WAS DISEASE CONTRACTED?  
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *NO.* DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? *yes.*  
 WHAT TEST CONFIRMED DIAGNOSIS? *autopsy.*  
 (Sign) *Charles H. Fisher*, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Poplar Bluff Mo* DATE OF BURIAL *6/23 1928*

20. UNDERTAKER *W. A. Stock* ADDRESS *2117 E. Grand*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

