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

Do not use this space.

35050

1. PLACE OF DEATH

County ..... Registration District No. 91

Township ..... Primary Registration District No. 003

City ..... (No. Central Hospital St. ..... Ward)

File No. .....

Registered No. 9753

2. FULL NAME Rosemary Morris

(a) Residence. No. 5119 Lotus Ave St., 6 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	Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 28, 1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
—		—	4	

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

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

PARENTS

10. NAME OF FATHER Harvey E Morris

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

12. MAIDEN NAME OF MOTHER Mariette Roberschmidt

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

14. INFORMANT Harvey E. Morris
(Address) 5119 Lotus Ave

15. FILED ....., 19.... Max C. Stackloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Sep 28, 1929, to Oct 2, 1929, that I last saw her alive on Oct 1, 1929, and that death occurred, on the date stated above, at 1:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Insufficiency
Neonatarum
157c
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Patulous Foramen Ovale
..... (duration) ..... yrs. ..... mos. ..... ds.

1595

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? .....

(Signed) D C C Emerson, M. D.
Oct 2 1929 (Address) 3870 Easton

*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
Calvary Cemetery	Oct 3 1929
20. UNDERTAKER Goodhart & Goodhart	ADDRESS 2228 St. Louis Ave

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