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

Do not use this space.

34730

File No. .....
Registered No. 10122

**1. PLACE OF DEATH**

County ..... Registration District No. 791
Township ..... Primary Registration District No. .....
City St Louis (No. City Hospital # 1003 St. ..... Ward)

**2. FULL NAME** Joseph W. Morrison

(a) Residence. No. 3147 Clark Ave St., 75 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) |
|---|---|---|
| M | W | Single |

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

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

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| Abt | 72 | - | ✓ | |

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

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

PARENTS

10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... ✓
(STATE OR COUNTRY) ✓
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... ✓
(STATE OR COUNTRY) ✓

14. INFORMANT John J. Stanley
(Address) St Louis Office

15. FILED OCT 22 1930 19 Max E. Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21/30 19

17. No Physician in attendance
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 3:50 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephrosclerosis
9 yrs (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? no
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Turner, M.D.
10/22/30 19 (Address) Dep. Coroner

*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 |
|---|---|
| St. Matthews | 10/24 1930 |
| **20. UNDERTAKER** | **ADDRESS** |
| Ziegenheim Bros. | 2621 Cherokee |

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 INDELIBLE INK—THIS IS A PERMANENT RECORD