

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.

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

Do not use this space.

31374

NOV 2 1935

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. 5885 Cates Ave.)

File No.....
 Registered No. **8213**
 St. Ward)

2. FULL NAME

Dr. David E. Morrow
 (a) Residence, No. 5885 Cates Ave. St. 5 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah E. Morrow
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 25, 1857
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 6 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Dentist
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Ohio

MOTHER 13. NAME M. K. Morrow

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

15. MAIDEN NAME M. K. Morrow

16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT Albert Morrow (ADDRESS) 5885 Cates Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Cem. DATE Oct. 1, 1935

19. UNDERTAKER Alexander & Sons (ADDRESS) 6175 Delmar

20. FILED SEP 30 1935 19 J. B. Redbeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1935 to Sept 28, 1935
 I last saw him alive on Sept 27, 1935. Death is said to have occurred on the date stated above, at 8:30 A.M.
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Senility
 Date of onset JAN 1935

Name of operation..... ✓ Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify.....
 (Signed) Maurice F. Reed M. D.
 (Address) 306 N. Grand Ave.

No Morris Street

Brand & Litchell

12:30 to 2 PM

63 to 8 PM

3063 J. rated

En 8995

Res 1443 McCauldwell

St 1033