

REC'D MAR 24 1938

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

8231

Do not use this space.

## 1. PLACE OF DEATH

(a) County St. Louis. 2 Registration District No. 784  
(b) Township Meramec. 1 Primary Registration District No. 200 Registered No. 412  
(c) City Pond (d) Street No. Pond, Mo. Clencoe, Mo. R. #1 St. Mo.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 0 yrs. 7 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Loyce Marie Morgan 625  
(a) Residence, No. 1 Pond, Mo. Clencoe, Mo. R. #1 St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 9-1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 8 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as saw mill, bank, etc. at home  
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) St. Louis, Co. Mo.

FATHER 13. NAME Otto Morgan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Casconade Co. Mo.

MOTHER 15. MAIDEN NAME Elsie Hibler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin, Co. Mo.

17. INFORMANT (ADDRESS) Mattie Hibler Clencoe, Mo. R. #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Pond, Mo. DATE Mar. 7-1938 Bethel Cem.

19. FUNERAL DIRECTOR (ADDRESS) Schradler Funeral Home Ballwin, Mo.

20. FILED 3-5 1938 J.R. Meyer Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 5-1938 1938

22. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1938 to March 5 1938

I last saw her alive on Feb. 26 1938 Death is said to have occurred on the date stated above, 6 a.m.

The principal cause of death and related causes of importance were as follows:

Branchial pneumonia

Other contributory causes of importance:

malnutrition 107

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) Henry Scott, M. D.

(Address) Ballwin, Mo.

1072

STATEMENT BY LICENSED EMBALMER

I, Theo. Schrader, Licensed Embalmer No. 3066

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E. Theo. Schrader

No. 3066 or by Registered Apprentice No. ✓

working under my personal supervision.

Signed Theo. Schrader

Licensed Embalmer No. 3066

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

8231 <sup>7</sup>  
Do not use this space.

1. PLACE OF DEATH

(a) County St Louis Registration District No. 784  
(b) Township \_\_\_\_\_ Primary Registration District No. 200 Registered No. \_\_\_\_\_  
(c) City Overland (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Joyce Marie Morgan  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
*(write the word)*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 5 - 1958

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

22. I HEREBY CERTIFY, That I attended deceased from

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

19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8 26

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

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

to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

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

Bronchial Pneumonia Date of onset \_\_\_\_\_  
There were no complications prior to or along with the pneumonia

FATHER 13. NAME \_\_\_\_\_  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Other contributory causes of importance:  
poor care in the home  
10/9/58

MOTHER 15. MAIDEN NAME \_\_\_\_\_  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

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.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

20. FILED 3/5 19 58 Henry Scott Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) Henry Scott, M. D.  
(Address) Balfurn mo

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

