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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13549

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3751

**1. PLACE OF DEATH:**  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Morgan 625

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Anna Morgan 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 25th, 1848.  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
91 3 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Okawville Illinois.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired.

11. Industry or business Driver.

MOTHER FATHER { 12. Name John Morgan

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Teritha Mathes

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Dougherty  
(b) Address 4220 Folsom Ave.

17. (a) Burial (b) Date thereof April 27, 40.  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Odd Fellows Cemetery.  
(c) Place: burial or cremation Okawville, Illinois.

18. (a) Signature of funeral director Ziegenhain Bros.  
(b) Address 2223 Cherokee Street.

19. (a) APR 25 1940 (b) J. B. Braddock  
(Date received by registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri. (b) County \_\_\_\_\_  
(c) City or town Saint Louis, 15  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4337 Oleatha Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23,  
year 1940 hour 10:55 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 21,  
1940, to April 23, 1940;  
that I last saw him alive on April 23, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis 6 days

Due to Arteriosclerosis year

Due to \_\_\_\_\_ year  
Other conditions Deafness, Squint year  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Walter Ford (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette, 4/21/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Juddie W. Ziegenhain*

Licensed Embalmer No. *22670*

P. O. Address *2623 Lakeside Dr*

**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.)**

**If this body is not embalmed, above space should be left blank.**