

S. No. 2
-11-10-39
5-17-39
-I X21492

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17184
State File No.

FILED JUN 15 1940
791

4662
Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3730 Maffitt Ave. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits write "RURAL")
(d) Street No. 3730 Maffitt Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Drucilla Morrison 625

3. (b) If veteran, name war _____ No. _____
3. (c) Social Security No. None

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

6. (b) Name of husband or wife John W.
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 23 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 11 2 hr. min.

9. Birthplace Bourbon Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown Eoff

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

14. Maiden name Unknown

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

16. (a) Informant Carl Morrison

(b) Address 3730 Maffitt Ave.

17. (a) Burial (b) Date thereof 5-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetary

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 27 1940 (b) J.F. Baskin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1940 hour 2:00 minute am.

21. I hereby certify that I attended the deceased from May 20, 1940, to May 25, 1940
that I last saw her alive on May 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Cerebral Hemorrhage 1 Day

Due to 80
Other conditions Tuber. Dorsalis ?
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Arthur H. DeMay (M. D. or other)
Address 4046 N. Grand Bl Date signed 5/26/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

J. B. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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.