

Registration District No. **1003**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **ST LOUIS**
(b) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **HOSPITAL 24 HRS**
(Specify whether years, months or days)
In this community **HOMER G. PHILLIPS**

3. (a) PRINT FULL NAME **THEOPHES MORRIS (b2)**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **499-05-6202**

4. Sex **Male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **6 9 1898**
(Month) (Day) (Year)

8. AGE: Years **42** Months **1** Days **2** If less than one day hr. min.

9. Birthplace **HUNTSVILLE ALA.**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business **POTTER IN REC PARLOR**

12. Name **ROBERT MORRIS**

13. Birthplace **CARTERSVILLE GA.**
(City, town, or county) (State or foreign country)

14. Maiden name **ALICE BLAKESHIP**

15. Birthplace **HUNTSVILLE ALA.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Allice L. Johnson**

(b) Address **1105 A RIDDLE ST**

17. (a) **BURIAL** (b) Date thereof **7 16 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WASHINGTON PARK**

18. (a) Signature of funeral director **C. W. BRUCE**

(b) Address **1003 N GARRISON Ave**

19. **JUL 15 1940** (b) **J. F. Brech**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County _____
(c) City or town **ST LOUIS** 11
(If outside city or town limits, write "RURAL")
(d) Street No. **2844 COOK Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **11th**
year **1948** hour **2:00** minute **A** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above:

Immediate cause of death **Acute Bullose Generalized Peritonitis** Duration _____
Control: Acute Appendicitis
Due to _____

Due to _____

Other conditions _____
(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 **Joseph M. Johnson** (M. D. or other) _____
Address **Deputy Coroner** Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

William C. McDowell....., Registered Apprentice No.....
working under my personal supervision.

Signed *William C. McDowell*
Licensed Embalmer No. *2114*

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.