5575
S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

12907

State File No. 3510

FILED APR 27 1942 791

Registration District No.

Primary Registration District No. 1003

Registrar's No.

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

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:
St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1Mo. 16Days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3839 a Kennerly Ave 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Walter I. Morrison

3. (b) If veteran, name war no

3. (c) Social Security No. 488-05-8239

4. Sex male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 0 single

6. (b) Name of husband or wife ----

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased March (Month) 24 (Day) 1917 (Year)

8. AGE: Years 25 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) 0 Missouri (State or foreign country)

10. Usual occupation unemployed

11. Industry or business unemployed

FATHER
12. Name Walter R. Morrison
13. Birthplace St. Louis (City, town, or county) 0 Mo (State or foreign country)

MOTHER
14. Maiden name Hazel Aubuchon
15. Birthplace Bonne Terre (City, town, or county) 0 Mo (State or foreign country)

16. (a) Informant Mrs. Hazel Morrison
(b) Address 3839 a Kennerly Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 20- 42 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ St Paul's Churchyard.

18. (a) Signature of funeral director A. Kron & H. Co.
(b) Address 2707 N. Grand Blv'd

19. (a) APR 20 1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17, year 1942 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from March 1, 1942, to April 17, 1942 that I last saw him alive on April 17, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	
Due to: Renal Tuberculosis.	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 13	
Major findings: Of operations: 13	
Of autopsy: as above.	

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature M. W. Davis (M. D. or other)
Address 1515 Lafayette Avenue, Date signed 4/17/42

(Licensed Embalmer's Statement on Reverse Side)

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 Paul F. Knoclenberg

Licensed Embalmer No. 2631

P. O. Address 2707 N Grand Bu

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, fact should be so stated above.