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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1943

Registration District No. 377

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 39169

Registrar's No. 2542

1. PLACE OF DEATH:

(a) County St. Louis,

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(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 Illinois (b) County Macon

(c) City or town Decatur
(If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME Hazel Morrison

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Herman Morrison

6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased August (Month) ~~28~~ (Day) 1911 (Year)

8. AGE: Years ~~32~~ 37 | Months 2 | Days 20 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business Archie G. Page

FATHER
12. Name ~~Unknown~~ Unknown
13. Birthplace ~~Unknown~~ Franklin Co. (City, town, or county) ~~Unknown~~ Ill. (State or foreign country)

MOTHER
14. Maiden name ~~Unknown~~ Flossie Cremmeens ~~Unknown~~
15. Birthplace ~~Unknown~~ Jefferson Co., Ill. (City, town, or county) ~~Unknown~~ (State or foreign country)

16. (a) Informant Herman Morrison

(b) Address Decatur, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/14/43 (Month) (Day) (Year)

(c) Place: burial or cremation Decatur, Illinois

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

(b) Address 4700 Washington Blvd,

19. (a) NOV 17 1943 (Date received local registrar) (b) E. G. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13 year 1943 hour 10;45 minute P. M.

21. I hereby certify that I attended the deceased from 11/7/43, 19..., to 11/13/43, 19...; that I last saw her alive on 11/13/43, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tumor of Brain Malignant	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Same	
Of autopsy Same	

54 b

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 .....

23. Signature J. M. Klemme (M. D. or other)

Address 4952 Maryland Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

FEB 7

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.....

Licensed Embalmer No.....3575.....

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, fact should be so stated above.