

No. 2
-5-43
5-17-39
1 X3667

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4408

FILED JAN 10 1944

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
6220 Lorraine Ave.
(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 (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 6220 Lorraine Ave.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Ed. R. Morris

3. (b) If veteran, name war No

3. (c) Social Security No. 493-03-1661

4. Sex Male

5. Color or Race White

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

6. (b) Name of husband or wife Josephine Morris

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased November 12, 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>39</u>	<u>1</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation Painter

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown
(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 Mrs. Josephine Morris

(b) Address 6220 Lorraine Ave.

17. (a) Removal (b) Date thereof Jan. 4, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prairie DuRocher, Ill.

18. (a) Signature of funeral director Calvin F. Feutz Funeral Home

(b) Address 4828 Natural Bridge Blvd.

19. (a) JAN 3 - 1944 (b) E. G. McEwan, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1, year 1944 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from 12-30-43, 19____, to 1-1-44, 19____; that I last saw him alive on 1-1-44, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Lobar)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 108

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 E. G. McEwan (M. D. or other)

Address 6201 Lake Ave Date signed 1-2-44

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

96
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96

0

MU1650
10-1-01

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 V E Morris

Licensed Embalmer No. 3360

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.