

S. No. 2
M-2-43
7-5-17-19
V-1-23507

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25966

State File No. _____

Registrar's No. 7340

FILED SEP 1 1945 318

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: St. Louis Children's Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution fifty six days
(Specify whether _____)
In this community 10 years
years, months or days

3. (a) PRINT FULL NAME Allen Thomas Morrison

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: 8 - 29 - 34
(Month) (Day) (Year)

8. AGE: Years 10 Months 11 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo. _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Allen B. Morrison
13. Birthplace Missouri _____
(City, town, or county) (State or foreign country)
14. Maiden name Willie Williams
15. Birthplace Missouri _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Haertlein
(b) Address Children's Hospital

17. (a) Burial (b) Date thereof Aug. 25-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cambell, Missouri

18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.

19. (a) AUG 23 1945 J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis _____
(If outside city or town limits, write "RURAL")
(d) Street No. 2504 Howard _____
(If rural, give location) 17 720
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21
year 1945 hour 3 minute 05 P.M.

21. I hereby certify that I attended the deceased from 6-27-45, 1945, to 8-21-45, 1945;
that I last saw him alive on 8-21-45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: one dullo blastoma

Due to _____

Due to 54

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

Major findings: Of operations _____
Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Gilbert B. Forster (M. D. or other) _____
Address 501 So. Kingshighway Date signed _____

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

0
17
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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 John P. Buchholz
Licensed Embalmer No. 1674
P. O. Address 2223 St. Louis Ave

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.