

V. S. No. 2
100M-5-43
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35657**
Registration District No. **318** Primary Registration District No. **100.3** Registrar's No. **9826**

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

1. PLACE OF DEATH:
 (a) County Saint Louis
 (b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 13 days
(Specify whether years, months or days)
 In this community 3 years

3. (a) PRINT FULL NAME Francis Morgan
 3. (b) If veteran, name war — 3. (c) Social Security No. —
 4. Sex Female 5. Color or race Colored
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Odesma Morgan 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased June 17 1918
(Month) (Day) (Year)

8. AGE:
 Years 27 Months 4 Days 22
 If less than one day — hr. — min.

9. Birthplace Tenn.
(City, town, or county) (State or foreign country)
 10. Usual occupation House Wife

MOTHER FATHER
 11. Industry or business —
 12. Name John Hurt
 13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Hubbards
 15. Birthplace —
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Odesma Morgan
 (b) Address 3841 Cooke Ave
 17. (a) Removal (b) Date thereof 11-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson, Tenn
 18. (a) Signature of funeral director Bernie Love
 (b) Address 3103 Washington
 19. (a) NOV 14 1945 (b) J. J. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 0-00
 (c) City or town St. Louis 11/17
(If outside city or town limits, write "RURAL")
 (d) Street No. 3841 Cooke Ave. 9
(If rural, give location)
 (e) Citizen of foreign country? — (Yes or No) 0
 If yes, name country —

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 8
 year 1945 hour 6 minute 25 P. M.
 21. I hereby certify that I attended the deceased from 9-25, 1945 to 11-8, 1945
 that I last saw her alive on Nov. 8, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis
 Duration 13 1/2
 Due to —
 Due to —
 Other conditions Cyesis
(Include pregnancy within 3 months of death)
 Major findings: Of operations —
 Of autopsy None
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 W. B. Bernard (M. D. or other) —
 Address 2601 N. Webster Date signed 11/9/45

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 *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.