V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22517

FILED JUN 30 1947 #71585 318

Registration District No. .....

Primary Registration District No. 1003

Registrar's No. 5951

WRITE PLAINLY—USING 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: City 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 Missouri (b) County Dod

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

(d) Street No. 3516 Magnolia Av (If rural, give location) 9

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

If yes, name country .....

3. (a) PRINT FULL NAME MARY MORGAN

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife 53

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

7. Birth date of deceased May (Month) 9 (Day) 1900 (Year)

8. AGE: Years 47 Months 1 Days 9 If less than one day ..... hr. ..... min.

9. Birthplace Hickory Flat Mississippi (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Aron Mc Neal
13. Birthplace Mississippi (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Charles W Morgan

(b) Address 3516 Magnolia

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/47 (Month) (Day) (Year)

(c) Place: burial or cremation New St Marcus Cemetery

18. (a) Signature of funeral director Wm E Mayfield Funeral Home

(b) Address 1926 Allen Av

19. (a) JUN 19 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th year 1947 hour 7:20 minute A M.

21. I hereby certify that I attended the deceased from 5/22/47 ....., 19....., to June 18th, 1947; that I last saw her alive on June 18th, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Laennec's Cirrhosis

Due to .....

Due to .....

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

Major findings:
Of operations .....

Of autopsy .....

Duration

PHYSICIAN

Underline the cause of 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 Wm J. Atkinson Jr. (M. D. or other) M.D.

Address 1515 Lafayette Date signed 6/18/47

Jefferson City Printing Co.

(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.....

Licensed Embalmer No.....

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.