S. No. 300
10-48

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6489

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1923

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

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 11
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 17
d. STREET ADDRESS (If rural, give location): 5630 Theodosia Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle):
c. (Last): Morris

4. DATE OF DEATH (Month) 2 (Day) 26 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan. 6, 1891
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ridgway, Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Wendell Wenzell
13b. MOTHER'S MAIDEN NAME: Frances Sauer
14. NAME OF HUSBAND OR WIFE: John C. Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: Elizabeth Holland, 9210 Meadowbrook — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebellar Apoplexy
DUE TO (c) 83a

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* 334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2:15 P m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] — Taylor Coroner
23b. ADDRESS
23c. DATE SIGNED: 2-28-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-1-49
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: FEB 28 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(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 .....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo

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.