

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10446

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State File No. 3108

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		
b. CITY OR TOWN <i>St. Louis</i>			c. CITY OR TOWN <i>ST. LOUIS</i>		
c. LENGTH OF STAY (in this place)			d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>3867A SHAW BLVD.</i>			<i>3867A SHAW BLVD.</i>		
3. NAME OF DECEASED (Type or Print)		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
		<i>THOMAS</i>	<i>W.</i>	<i>MORRIS</i>	<i>4-4-49</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)
		<i>MARRIED</i>		<i>AUG 20-1876</i>	<i>72 YRS</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>NIL</i>				<i>ST. LOUIS MO</i>	<i>U. S. A.</i>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
<i>THOMAS MORRIS</i>		<i>EUNICE BARTLET</i>		<i>STELLA MORRIS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
<i>NO</i>		<i>NO</i>		<i>Mrs Stella Morris 3867^c Shaw Bl</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			MEDICAL CERTIFICATION		
			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocardial Failure</i>		
			ANTECEDENT CAUSES		
			DUE TO (b) <i>Chronic Myocarditis</i>		
			DUE TO (c) <i>Rheumatic Heart Disease</i>		
			II. OTHER SIGNIFICANT CONDITIONS		
			<i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
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)	
				<i>H. 2 2 2</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 1947, to <i>4/4</i> , 1949, that I last saw the deceased alive on <i>4/4</i> , 1949, and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title)			23b. ADDRESS		23c. DATE SIGNED
<i>Hugh Haynes MD</i>			<i>3720 Washington</i>		<i>4/15/49</i>
24a. BURIAL CREMATION REMOVAL (Specify)		24b. DATE	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)
<i>BURIAL</i>		<i>APRIL 7-49</i>	<i>CALVARY CEM.</i>		<i>St. Louis MO</i>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>APR 6 1949</i>		<i>E. J. Schuur</i>		<i>3125 Lafayette Ave</i>	

AUG 10 1944

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.

Signed _____

Joseph Vollmer

Signed _____
Student Embalmer

Licensed Embalmer No. *41014*

P. O. Address, *3125 Lafayette*

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.