

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 11 1949

State File No. **14019**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2854**

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis) c. LENGTH OF STAY (In this place) 20 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2656 Lucas Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Mable	b. (Middle) _____	c. (Last) Morrow	4. DATE OF DEATH (Month) (Day) (Year) April 24 1949
--	-------------------	-------------------------	---

5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 30, 1899	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months 6	IF UNDER 1 YEAR Days 24	IF UNDER 24 HRS. Hours _____ Min. _____
------------------------	---------------------------------	--	--	---	---------------------------------	--------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Malissa ?	14. NAME OF HUSBAND OR WIFE Commonlaw - Sidney Dyons
-----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state war or dates of service) Not indicated	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St	ADDRESS _____
--	--	---	---------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	ANTECEDENT CAUSES *Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) "		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	--	--

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) 13
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? acc
---	--	---------------------------------------

22. I hereby certify that I attended the deceased from **4-21**, 19 **49** to **4-24**, 19 **49** that I last saw the deceased alive on **4-24**, 1949, and that death occurred at **3:20 a.m.** from the causes and on the date stated above.

22a. SIGNATURE [Signature] (Degree or title) M. D.	23b. ADDRESS 2601 N. Whittier St	23c. DATE SIGNED 4-27-49
--	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE APR 30 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) _____
---	------------------------------	--	---

DATE REC'D BY LOCAL REG. APR 30 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] Rowland Mortuary Service 4104 Manchester Ave.
---	--	--

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

21

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.....

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.