

0.300
0.48

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25132**
Registrar's No. **6346**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY SANITARIUM		e. STREET ADDRESS (If rural, give location) 5300 ARSENAL			
3. NAME OF DECEASED (Type or Print) SARA H MORRISON			4. DATE OF DEATH (Month) (Day) (Year) July 21 1949		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH NOV 1 - 1879	9. AGE (In years last birthday) 69	10. CITIZEN OF WHAT COUNTRY? WISCONSIN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13a. FATHER'S NAME JAMES MORRISON		13b. MOTHER'S MAIDEN NAME ANNA UNKNOWN		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME Margaret Kelly	
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) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. XXXX (b) Chronic Ulcer- left leg DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 1944x
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 930	
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? H200	
22. I hereby certify that I attended the deceased from May 1 , 19 45 , to July 21 , 19 49 , that I last saw the deceased alive on July 21, 1949 , and that death occurred at 6:15 AM , from the causes and on the date stated above.					
23a. SIGNATURE Jack R. Riedelmann			23b. ADDRESS 15400 Arsenal St		23c. DATE SIGNED 7/21/49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-22-49	24c. NAME OF CEMETERY OR CREMATORY SALVARY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
DATE REC'D BY LOCAL REG. JUL 22 1949		REGISTRAR'S SIGNATURE J. B. Casater		25. FUNERAL DIRECTOR'S SIGNATURE Bullen Kelly	
				ADDRESS 4386 Lindell	

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

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 Ralph W. Henson

Signed _____
Student Embalmer

Licensed Embalmer No. 3791

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.