

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6532

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1665**

1. PLACE OF DEATH a. COUNTY		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 township) OR TOWN, St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1439 Morrison Ave.,		d. STREET ADDRESS (If rural, give location) 1439 Morrison Ave.,	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) E. c. (Last) Morris	4. DATE OF DEATH (Month) (Day) (Year) Feb. 19 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 19, 1904	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months 5 Days 0	IF UNDER 24 HRS. Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Clerk	10b. KIND OF BUSINESS OR INDUSTRY Clayton Co. Bank	11. BIRTHPLACE (State or foreign country) Indianapolis Indiana	12. CITIZEN OF WHAT COUNTRY? /
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13a. FATHER'S NAME Charles Morris	13b. MOTHER'S MAIDEN NAME Carrie Millner	14. NAME OF HUSBAND OR WIFE Anna L. Montgomery Morris
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 315-05-3910	17. INFORMANT'S SIGNATURE OR NAME Anna L. Morris	ADDRESS 1439 Morrison Ave.,
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Hemorrhage 6 months		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Tuberculosis 10 yrs			
19a. DATE OF OPERATION	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) MO LX
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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?
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22. I hereby certify that I attended the deceased from Jan 19 50, to Feb 19 50, that I last saw the deceased alive on Feb 17, 1950, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE W.A. Schumacher M.D.	(Degree or title)	23b. ADDRESS 8816 W. Charles St.	23c. DATE SIGNED Feb 20 50
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24a. BURIAL (Cremation, Removal) Burial	24b. DATE 2-23-50	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 20 1950	REGISTRAR'S SIGNATURE J.B. Luster	25. FUNERAL DIRECTOR'S SIGNATURE Cullinane Bros.	ADDRESS 3320 N. Kingshighway
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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.

Student
Student Embalmer

Signed Fred Frick _____

Licensed Embalmer No. 3186 _____

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.