

FILED APR 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15425

State File No. ....

Registrar's No. 916

|  |                                  |  |  |  |  |   |                                |  |                           |                                  |  |
|--|----------------------------------|--|--|--|--|---|--------------------------------|--|---------------------------|----------------------------------|--|
| BIRTH NO. ....   |                                  | REG. DIST. NO. <u>317</u>  |  | PRIMARY REG. DIST. NO. <u>6076</u>   |  | State File No. ....   |                                | Registrar's No. <u>916</u>   |                           |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>  |  |   |                                |  |                           |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Jefferson Brks, Mo.</u>  |                                  |  | c. LENGTH OF STAY (in this place) .....            |  |  | c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> |                                |  | 8870                      |                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1039 Van Nostrand</u>   |                                  |  |  | d. STREET ADDRESS (If rural, give location) <u>1039 Van Nostrand</u>   |  |   |                                |  |                           |                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Mary</u> b. (Middle) <u>Morris</u> c. (Last) .....   |                                  |  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Apr. 7, 1950</u>  |  |   |                                |  |                           |                                  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>                               |  | 8. DATE OF BIRTH<br><u>Sep. 29, 1891</u>   |  | 9. AGE (In years last birthday) <u>58</u>   | IF UNDER 1 YEAR<br>Months      | IF UNDER 24 HRS.<br>Days   | IF UNDER 24 HRS.<br>Hours | IF UNDER 24 HRS.<br>Min.         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>   |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>St. Louis, Mo.</u>                                     |   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |                           |                                  |  |
| 13a. FATHER'S NAME<br><u>John Brown</u>  |                                  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Bridget Cannon</u> |  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Fred Morris</u>                                     |                                |  |                           |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |                                  | 16. SOCIAL SECURITY NO. <u>non</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Fred Morris 1039 Van Nostrand</u>  |  |   |                                |  |                           |                                  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                          |                                  |  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) <u>generalized Arteriosclerosis</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |                                |  |                           | INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION<br><u>331X</u>  |  |  |  |   |                                | 20. AUTOPSY?<br>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)  |  |   |                                |  |                           |                                  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.   |                                  | 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 <u>Jan 4 1950</u> , to <u>April 7, 1950</u> , that I last saw the deceased alive on <u>4/7, 1950</u> , and that death occurred at <u>4308</u> m., from the causes and on the date stated above. |                                  |  |  |  |  |   |                                |  |                           |                                  |  |
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title)  |                                  |  |  | 23b. ADDRESS <u>752 Lemay Ferry Rd.</u>  |  |   | 23c. DATE SIGNED <u>4/8/50</u> |  |                           |                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 24b. DATE <u>4-10-50</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>                       |                                |  |                           |                                  |  |
| DATE REC'D BY LOCAL REG. <u>4-8-50</u>   |                                  | REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Southern Funeral Home</u><br><u>6322 S. Grand Blvd.</u> |   |                                |  |                           |                                  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

Dr. Vige  
752 Linnay Ferry Rd  
Sw 3407  
10 30 - 1 P.M.

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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....

Signed David Van Fossen

Licensed Embalmer No. 4242

P.O. Address 6322 So Grand

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.