

FILED JUN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21840**
Registrar's No. **3149**

BIRTH NO. _____ 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3656 Keokuk		d. STREET ADDRESS (If rural, give location) 3656 Keokuk 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Paul	b. (Middle) F.	c. (Last) Morgenroth	4. DATE OF DEATH (Month) (Day) (Year) 6/11/50
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 18, 1872	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 78
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. of Meda-Physic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany 4	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Otto Morgenroth	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sophia
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No XXXXXXXX	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Sophia Morgenroth, 3656 Keokuk	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 months
	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. 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 4200
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22. I hereby certify that I attended the deceased from **April 1, 1950**, to **June 11, 1950** that I last saw the deceased alive on **June 9, 1950**, and that death occurred at **6:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert J. Gnude M.D.	23b. ADDRESS 3606 Gravois	23c. DATE SIGNED 6/12/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 6/13/50	24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 12 1950	REGISTRAR'S SIGNATURE J. B. Fawcett	25. FUNERAL DIRECTOR'S SIGNATURE Wasku-Heldule H. F. L. Co.	ADDRESS 3634 Gravois
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed..... *Frank J. Hyland Sr.*

Signed.....

Student Embalmer

Licensed Embalmer No. *2645*

P. O. Address *St. Louis*

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.