No. 300
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FILED JAN 2 1951

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13218

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 3062

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Koch, Mo
c. LENGTH OF STAY (In this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Robert Koch Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY St. Louis City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2269
d. STREET ADDRESS (If rural, give location) 832 a Farrar

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) c. (Last) Morgan
4. DATE OF DEATH (Month) Dec. (Day) 17 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 4-27-87 (?)
9. AGE (In years last birthday) 63 (?) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight handler
10b. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME James Morgan
13b. MOTHER'S MAIDEN NAME Martha Lee
14. NAME OF HUSBAND OR WIFE Mertie Morgan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 489-26-3508
17. INFORMANT'S SIGNATURE OR NAME Record of Robert Koch Hospital ADDRESS Koch Mo.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Miliary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH 2 months

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. Tuberculous pericarditis — 11X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 011X
20. AUTOPSY? YES ☒ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12-, 1950, *to* 12-17-, 1950, *that I last saw the deceased alive on* 12-17-, 1950, *and that death occurred at* 9:25 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Axel R. Lorman, M.D. (Degree or title)
23b. ADDRESS Robert Koch Hospital, Koch, Mo.
23c. DATE SIGNED 12-18-50

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 12-19-50
24c. NAME OF CEMETERY OR CREMATORY FRIEDENS CEM.
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.

DATE REC'D BY LOCAL REG. 12/19/50
REGISTRAR'S SIGNATURE Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE SUEDMEYER SONS
ADDRESS 3934 N. 20TH

(Licensed Embalmer's Statement on Reverse Side)

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 Neville B. Grohwetter

Licensed Embalmer No. 3696

P. O. Address 3934 N. 20th ST.

Signed.....
Student Embalmer

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.