

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35420

State File No.

FILED NOV 2 1951

9074

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **100** Registrar's No.

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 1 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL #1		e. STREET ADDRESS (If rural, give location) 3839^A KENNERLY	

3. NAME OF DECEASED (Type or Print) HAZEL I MORRISON	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 10-14-51
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 12-30-1897	9. AGE (In years last birthday) 53	# UNDER 1 YEAR Months	# UNDER 1 HR. Hours	# UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS	10b. KIND OF BUSINESS OR INDUSTRY WORK CLOTHING	11. BIRTHPLACE (State or foreign country) BONNE TERRE MO	12. CITIZEN OF WHAT COUNTRY? U
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13a. FATHER'S NAME M. AUBUCHON	13b. MOTHER'S MAIDEN NAME FANNIE JONES	14. NAME OF HUSBAND OR WIFE WALTER R. MORRISON
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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. U	17. INFORMANT'S SIGNATURE OR NAME Myrtle Eaton	ADDRESS 3637^A Tolson
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 hrs 45 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from left femoral artery		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Enosis of vessel by carcinoma DUE TO (c) Ca. of Uterus		
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? 176X
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22. I hereby certify that I attended the deceased from **Feb**, 19**48**, to **present**, 19**51**, that I last saw the deceased alive on **Oct. 10**, 19**51**, and that death occurred at **2:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE Joseph F. Tigg, M.D.	(Degree or title)	23b. ADDRESS 508 N. Grand	23c. DATE SIGNED 10/17/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-17-51	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	24d. LOCATION (City, town, or county) (State) St. Louis Co. MO
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DATE REC'D BY LOCAL REG. OCT 15 1951	REGISTRAR'S SIGNATURE A. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE A. Knox Sells	ADDRESS 2707 N. Grand
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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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

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.