

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35421
State File No. 9187
Registrar's No.

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 2199	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION BERNARD NURSING HOME		d. STREET ADDRESS (If rural, give location) 4406 McPHERSON AVE;	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) - - - - c. (Last) MORRISON.			4. DATE OF DEATH (Month) (Day) (Year) Oct. 16, 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 8, 1868	9. AGE (In years last birthday) 83	10. UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Owens Glass Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Philadelphia, PA.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME George Morrison	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Helen M. Morrison.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Helen M. Morrison, ADDRESS 4406 McPherson Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Co of Sigmund Olson		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus. Bladder Stone.		
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____		
		DUE TO (c) _____		
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X

22. I hereby certify that I attended the deceased from _____, 19____, to 10-16-1951, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Carnell M.D.	23b. ADDRESS 895 2 Maryland	23c. DATE SIGNED 10-18-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-18-1951	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery; St. Louis. Mo.
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. OCT 18 1951	REGISTRAR'S SIGNATURE Pearl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

