

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3134**
0199

FILED JAN 26 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town)		a. STATE	
c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township)	
Homer G Phillips Hospital		Missouri	
		2219	
		St. Louis	
		2	
		2606 Dayton	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First)	b. (Middle)	c. (Last)	(Month) (Day) (Year)
Ruth		Morrow	January 3 1952
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
F	Negro		June 9, 1915
3			36
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
Housewife		None	
10a. USUAL OCCUPATION		11. BIRTHPLACE (State or foreign country)	
Housewife		Tennessee	
		1	
		U.S.A.	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
No	None	Ruth Gandy	2606 Dayton

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 Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)		
	Cerebral Vascular Hemorrhage		
ANTECEDENT CAUSES			
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Undetermined	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Post-operative craniotomy for	
Conditions contributing to the death but not related to the disease or condition causing death.		hematoma of parietal occipital lobe.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	Epilepsy, secondary	

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) (Min)	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 7-15 19 51 to 1-3, 19 52, that I last saw the deceased alive on 1-3, 19 52, and that death occurred at 12:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
<i>[Signature]</i>	M. D. 2601 N Whittier St	1-4-52

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	1-9-52	Oakdale Cem	St Louis 60, Mo

DATE REC'D BY LOCAL REG. JAN 8 1952	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS 1221 N. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Student Embalmer

Signed *Clarence Proctor*

Licensed Embalmer No. *4755*

P. O. Address *1231 N York*

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.