V.S. No. 300
REV. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1952

State File No. 33255

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8606

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

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2239
d. STREET ADDRESS (If rural, give location): 23 1721 Lafayette St.

3. NAME OF DECEASED (Type or Print)
a. (First): Augusta
b. (Middle):
c. (Last): Morris

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 3
8. DATE OF BIRTH: 6-21-1932
9. AGE (In years last birthday): 20
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): Office Worker
10b. KIND OF BUSINESS OR INDUSTRY: Insurance Co.
11. BIRTHPLACE (City and State or Foreign Country): Arkansas
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Humphreys, Maness
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE:

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

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Ulcerative Colitis — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

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: 9-28-52
19b. MAJOR FINDINGS OF OPERATION: Ileostomy
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?

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22. *I hereby certify that I attended the deceased from* 7-10, 1952, *to* 9-13, 1952, *that I last saw the deceased alive on* 9-13, 1952, *and that death occurred at* 5:20 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: William T. Fitzgerald (Degree or title) M.D.
23b. ADDRESS: 1325 So. Grand Blvd.
23c. DATE SIGNED: 9-13-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Sept. 13, 1952
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Stamp, Ark.

DATE REC'D BY LOCAL REGISTRAR: SEP 15 1952
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McLaughlin Funeral Home - St. Louis, Mo.
MBC
(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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed James R. Chapman

Licensed Embalmer No. X5-50

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.