No. 300
10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43856

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11617

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis,Mo.
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): ST. LOUIS CITY HOSPITAL #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 2269 26 1119 N.Market St. 0

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

4. DATE OF DEATH (Month) (Day) (Year): 12 19 54

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 9,1886
9. AGE (In years last birthday): 68 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): Pittsburgh,Penn.
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME: Joseph Lazkowitz
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Robert Morgan
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: Robert E.Morgan
ADDRESS: 1119 N.Market St.

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) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH

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
19b. MAJOR FINDINGS OF OPERATION
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? 332X

22. *I hereby certify that I attended the deceased from* 12-8, *1954, to* 12-19, *1954, that I last saw the deceased alive on* 12-19, *1954, and that death occurred at* 5:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jim H. Maier
23b. ADDRESS: 1515 Lafayette Ave.
23c. DATE SIGNED: 12-21-54

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 12-22-54
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24d. LOCATION (City, town, or county) (State): St.Louis,Mo.

DATE REC'D BY LOCAL REG.: DEC 21 1954
REGISTRAR'S SIGNATURE: J Carl Smith MD
MKB
25. FUNERAL DIRECTOR'S SIGNATURE: Sullivan's
ADDRESS: 2849 N.Euclid Ave.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Albert Mayfield Jr.

Licensed Embalmer No. 307

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.