

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003 State File No. 27988  
7121

318

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or town) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge</b>		STREET ADDRESS (If rural, give location) <b>4224 Shenandoah</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Michael</b>	b. (Middle) <b>Peter</b>	c. (Last) <b>Mor</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>8/13/55</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>March 25, 1870</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) <b>Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Cent. Deco.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hungary</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Michael Moritz</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Kremer</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>495-14-4737</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Bertha Kurusz</b>	ADDRESS <b>4224 Shenandoah</b>
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18. CAUSE OF DEATH. Enter only one cause on line for (a), (b), and (c).  *This does not mean the mode of dying such as heart failure, pneumonia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		
	ANTECEDENT CAUSES *Turbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Pyelonephritis</b>		
19. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19. MAJOR FINDINGS OF OPERATION <b>6000</b>	20. AUTOPSY? YES <input checked="" 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?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **2:04 am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>John &amp; Mackay J. mo</b>	(Degree or title)	23b. ADDRESS <b>3720 Washington</b>	23c. DATE SIGNED <b>Aug 15, 1955</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>8/17/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>AUG 15 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E.J. Schnur</b>	ADDRESS <b>3125 Lafayette Ave.</b>
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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Thomas R. Terwisk*

Licensed Embalmer No. *379*

P. O. Address *3125 Lakewood*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.