

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38655

82421-55  
FILED DEC 2 1955

State File No. \_\_\_\_\_

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **10147**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>			e. STREET ADDRESS (If rural, give location) <b>20 2129a Howard St.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>EVELYN</b> b. (Middle) <b>RUTH</b> c. (Last) <b>MORRISON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 20, 1955.</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>infant</b>	8. DATE OF BIRTH <b>Oct. 2, 1955</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <b>1 18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Billy Morrison</b>		13b. MOTHER'S MAIDEN NAME <b>Virginia Chaffin</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Billy Morrison 2129a Howard St.</b>			
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 <b>10/2/55 + 11/20/55</b>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral palsy</b>			DUE TO (b) <b>"</b>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Anemia; convulsions; edema</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>351x</b>			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) m. <b>noon</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>?? CP. Probably pie nated or nated</b>			
22. I hereby certify that I attended the deceased from <b>10-24</b> , 19 <b>55</b> , to <b>11-20</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>11-20</b> , 1955, and that death occurred at <b>2:40 p.</b> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <b>V.H. Peden</b>			23b. ADDRESS <b>W. D. 1515 LAYETTE AVE.</b>		23c. DATE SIGNED <b>11-21-55.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11-21-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>			
DATE REC'D BY LOCAL REG. <b>NOV 21 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hy. Leidner Und. Co. 2223 St. Louis Ave.</b>		

(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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No.....

P. O. Address.....

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.