FILED APR 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14748

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3396

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
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): 1929 Belle Glade Ave.

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
d. STREET ADDRESS (If rural, give location): 1929 Belle Glade Ave.

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

4. DATE OF DEATH (Month) April (Day) 1, (Year) 1956

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: 8/20/1890
9. AGE (In years last birthday): 65 — 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): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: unemployed
11. BIRTHPLACE (City and State or Foreign Country): Dalas, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Hiram Molone
13b. MOTHER'S MAIDEN NAME: Lillie Crump
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.: none
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Hallie Drake - 1929 Belleglade Ave.

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): Cancer Colon

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.: Paralysis Right side

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 153x
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?

22. *I hereby certify that I attended the deceased from* 9/1, 1955, *to* 3/31, 1956, *that I last saw the deceased alive on* 3/20, 1956, *and that death occurred at* 11:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. J. Sneyg M.D.
23b. ADDRESS: 11 N Jefferson Ave
23c. DATE SIGNED: 4/3/56

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: April 6, 1956
24c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: APR 5 1956
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Atkins Bros. - 3644 Finney 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 embalmed by me, or by _____

_____, Student Embalmer No. _____

working under my personal supervision.

Student .....
Student Embalmer

Signed S J Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chester

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

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