

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19087

FILED MAY 24 1957

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **4388** Registrar's No.

health, Welfare, Public service  
000 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V. A. Hosp, 915 Grand</b>				Length of stay in lb <b>22</b>		d. STREET ADDRESS (If outside, give location) <b>2315 Clark Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Emery</b> Middle <b>Morgan</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1898</b>	
9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b>15</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (City and state or country) <b>Georgia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Will Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I</b>		17. INFORMANT Address <b>Mrs. Merline Morgan 2315 Clark</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Asthmaticus</b> DUE TO (b) <b>Spinal Anesthesia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>612x</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>While under gang operation for prostate gland) at Veteran's Hosp.</b>					
20c. TIME OF INJURY Hour <b>5</b> a. m. <b>56</b> p. m. <b>57</b>		Month, Day, Year <b>5 6 57</b>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg, etc.) <b>Hosp</b>			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>		20g. COUNTY STATE			
21. I attended the deceased from <b>225 P.</b> to <b>1</b> and last saw her/him alive on <b>5-8-57</b> . Death occurred at <b>225 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Dr. or title) <b>James M Kelly Deputy</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>5-8-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/10/1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Detroit, Michigan</b>	
24. FUNERAL DIRECTOR ADDRESS <b>G. Wade Grenberry 4202 Finney Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 8 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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: *Leroy H. Bannister*  
Licensed Embalmer No. 45

P. O. Address 4251 9th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.