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Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19088
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5261

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐ c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP. #1 — Length of stay in Hospital or Institution: 25	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri — b. COUNTY: c. CITY OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐ d. STREET ADDRESS (If outside, give location): 3208 Olive St — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EVELYN Middle Wenger Last MORGAN

4. DATE OF DEATH: Month MAY Day 31 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 21, 1925

9. AGE (In years last birthday): 32 — 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): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City and state or country): Oregon

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Un Known

14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: St. Louis City Hospital — Address: 1515 Lafayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Debilitation
DUE TO (c) Advanced Pulmonary Tuberculosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002x

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5/21/57 to 5/31/57 and last saw her/him alive on 5/31/57
Death occurred at 2:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Thos. C. Kouch M.D.

22b. ADDRESS: 1515 LAFAYETTE

22c. DATE SIGNED: 6/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 6-7-57

23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery

23d. LOCATION (City, town, or county) (State): Salem Oregon

24. FUNERAL DIRECTOR: Alexander & Sons — ADDRESS: 6170 Delmar

25. DATE RECD. BY LOCAL REG.: JUN 5 '57

26. REGISTRAR'S SIGNATURE: J Carl Smith MD

(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 em

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

working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed Josie McCullah

Licensed Embalmer No. 24

P. O. Address 6 [illegible]

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.