

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042006

STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10560

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>3319 Abner Place</b>  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>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</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>01 3319 Abner Place 2067</b> Length of stay in lb                              |                           | d. STREET ADDRESS (If outside, give location) <b>3319 Abner Place</b> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>            |  |
| 3. NAME OF DECEASED (Type or print) <b>William</b> First <b>J.</b> Middle <b>Morio</b> Last   |                           | 4. DATE OF DEATH <b>Nov. 2, 1958</b> Month <b>Nov.</b> Day <b>2</b> Year <b>1958</b>   |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2/7/1879</b>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switchman</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>  | 11. BIRTHPLACE (City and state or country) <b>New York State /</b> |
| 13. FATHER'S NAME <b>Andrew Morio</b>   |                           | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <b>Yes Spanish Amer.</b>                            |                           | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <b>Mrs. Clara Leonard</b>   |                           | Address <b>3319 Abner Pl.</b>  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>  |  | INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>  |  | <b>2 1/2 YRS</b>   |
| DUE TO (c) <b>ARTERIO SCLEROSIS, GENERALIZED</b>   |  | <b>2 1/2 YRS</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input 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.) |  |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 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 <b>FEB. 26, 1956</b> to <b>Nov. 2, 1958</b> and last saw <sup>her</sup> him alive on <b>Nov. 2, 1958</b><br>Death occurred at <b>6:00 am</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |
| 22a. SIGNATURE (Degree or title) <b>Robert A. Hall, M.D.</b>   | 22b. ADDRESS <b>3902 LAFAYETTE St. Louis, Mo.</b>  | 22c. DATE SIGNED <b>Nov. 3, 1958</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE <b>11/5/1958</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Natl. Cem. Jefferson Barracks, Jeff. Barracks MO</b>     |
| 24. FUNERAL DIRECTOR <b>Cullinane Bros.</b>  | 25. DATE RECD. BY LOCAL REG. <b>MM/5 '58</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

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causes.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Laurence O. Gering*  
.....

Licensed Embalmer No. 4

P. O. Address .....

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.