

# JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037895

FILED VS NOV 3 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9783**

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4143 W. Kossuth</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>4143 W. Kossuth Ave</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>Maud,</b> Middle <b>Morgan</b> Last _____			<b>4. DATE OF DEATH</b> Month <b>10-</b> Day <b>22-</b> Year <b>59</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/12/1893</b>	<b>9. AGE</b> (last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House wife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Louisiana</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.</b>
<b>13a. FATHER'S NAME</b> <b>Emile Corney</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anneh Jones</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>George Morgan</b>		

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Vivian Bernard 4143 W. Kossuth</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>332x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____
<b>21. I attended the deceased from</b> <b>April 2, 1958</b> to <b>Oct 22, 1959</b> and last saw her/him alive on <b>Oct. 22, 1959</b> Death occurred at <b>9 hrs</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

<b>22a. SIGNATURE</b> <i>J. W. Howard</i> (Degree or title) <b>M.D.</b>	<b>22b. ADDRESS</b> <b>5593 Caven Rd</b>	<b>22c. DATE SIGNED</b> <b>10-12-59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE</b> <b>10-26-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Park</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>J. McClendon 4535 Washington Ave.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 26 1959</b>	REGISTRAR'S SIGNATURE <i>Hoan Smith</i> <b>M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

*S.P.*

DOCUMENT

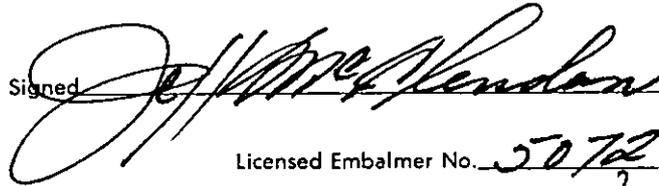
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 5072

P. O. Address 4535 Kern

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.