

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 19 1959

59-037896

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 8742**

RECEIVED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> Length of stay in 1b <u>11 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>En route to Home of Phillip</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY _____ c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>4562 McMillen</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Diana</u> <u>Morris</u>			4. DATE OF DEATH Month Day Year <u>9</u> <u>20</u> <u>59</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9.9.59</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Hubert Morris</u>		13b. MOTHER'S MAIDEN NAME <u>Ermagine Morris</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Lama Jane Morris 4562 McMillen</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation (suicide).</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>916.016</u>					INTERVAL BETWEEN ONSET AND DEATH		
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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 this 18.) <u>Caused by suicide resulting from life in home.</u>				
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>?</u> <u>9</u> <u>1959</u> <u>September</u> <u>19</u> <u>1959</u>	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.) <u>123 Home</u>	20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>	COUNTY _____ STATE _____		
21. I attended the deceased from _____ to _____ and last saw her alive on _____. Death occurred at <u>718 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Deen M. Zumbro</u>			22b. ADDRESS <u>1200 Clark</u>		22c. DATE SIGNED <u>9/23/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9 23 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dixon</u>		23d. LOCATION (City, town, or county) (State) <u>151stwood Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>A. H. Burke 3506 Franklin</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 23 59</u>		26. REGISTRAR'S SIGNATURE <u>Leon Smith, M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

227 19 23

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

No Embalming.
Carl Burkhardt M.D.

Licensed Embalmer No. _____

P. O. Address _____

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.