

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 21 1959

'59 0 4 5 7 5 3

211017

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE MISSOURI b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 30 YRS		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION INCARNATE WORD HOSP			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2919 A BELT		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W Last MORGAN			4. DATE OF DEATH Month Nov - Day 28 - Year 1959					
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN-17-1882	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINT SPRAYER			10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (City and state of country) MURPHYSBORO - ILL		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME WILLIAM MORGAN			13b. MOTHER'S MAIDEN NAME ISABELLE GONES			14. NAME OF HUSBAND OR WIFE TDA MORGAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 488-09-7794		17. INFORMANT Address William Morgan, 2919 A Belt			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cinchois of the Licker							INTERVAL BETWEEN ONSET AND DEATH 0 YRS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 581.0								
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 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 _____ s.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 DEC. 28 , to NOV 09 and last saw him alive on 27 NOV 09 Death occurred at 7 a m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Walter Byrne, M.D. (Degree or title)				22b. ADDRESS 4660 Maryland			22c. DATE SIGNED 28 NOV 09	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE NOV-30-1959		23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY - MO		
24. FUNERAL DIRECTOR L.B. Tanner, 6107 Natural Bridge ADDRESS				25. DATE RECD. BY LOCAL REG. NOV 30 1959		26. REGISTRAR'S SIGNATURE Lead Smith, M.D.		

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

Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis,

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.