

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003839

FILED VS JAN 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 544** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 1 yr. 10		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 Chronic Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1404a Belt		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First William Middle Morrell Last Morrell				4. DATE OF DEATH Month 1 Day 13 Year 60											
5. SEX Male		6. COLOR OR RACE Col.		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-8-1886		9. AGE (last birthday) 73		IF UNDER 1 YEAR Months 10 Days 5		IF UNDER 24 HR Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) Mo. St. Louis		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Charles Morrell				13b. MOTHER'S MAIDEN NAME Elizabeth Price				14. NAME OF HUSBAND OR WIFE -							
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. 448-03-7639 A		17. INFORMANT Address Edna Dixon 1404a Belt Ave									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basine Congestion of Lungs DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 1 mo. 2 yrs. 2 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0								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 _____ a.m. _____ p.m. Month, Day, Year _____				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 2-18-57 to 1-13-60 and last saw her alive on 1-13-60 Death occurred at 2:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.						22b. ADDRESS 5800 Arsenal				22c. DATE SIGNED 1/14/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-16-1960		23c. NAME OF CEMETERY OR CREMATORY Oak Dale				23d. LOCATION (City, town, or county) St. Louis Co. Mo.		23e. REGISTRAR'S SIGNATURE Earl Smith, M.D.					
24. FUNERAL DIRECTOR ADDRESS J. H. RANDLE & SON 3133 Bell Ave.				25. DATE RECD. BY LOCAL REG. JAN 15 1960				26. REGISTRAR'S SIGNATURE Earl 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

Ethel K. Harv

Licensed Embalmer No. 4175

P. O. Address 4181 Was

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.