

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2 4161 60-017165
STATE FILE NUMBER

FILED VS APR 25 1960

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) a. STATE Missouri b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b		c. CITY OR TOWN Saint 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 5936a Romaine			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5936a Romaine		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First EMMA Middle MORRIS Last				4. DATE OF DEATH Month 4 Day 13 Year 1960											
5. SEX Female		6. COLOR OR RACE Negro		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3/30/78		9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook			10b. KIND OF BUSINESS OR INDUSTRY Private Family			11. BIRTHPLACE (City and state or country) Charlotte, N.C.			12. CITIZEN OF WHAT COUNTRY U.S.A.						
13a. FATHER'S NAME Clark Dixon			13b. MOTHER'S MAIDEN NAME Nancy Crawford			14. NAME OF HUSBAND OR WIFE Ellis Morris									
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. none		17. INFORMANT Daisy White			Address 5936a Romaine							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Gastro Intestinal Tract with Metastasis										INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 159x															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Jan. 1956 to 4/12/60 and last saw her/him alive on 4/12/60 Death occurred at 12:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Do not write in title) Thomas W. Little M.D.						22b. ADDRESS 3167 Sheridan Avenue				22c. DATE SIGNED 4/14/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/19/60		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery			23d. LOCATION (City, town, or county) St. Louis, Mo.			(State)					
24. FUNERAL DIRECTOR Charles J. Gates				ADDRESS 4107 Finney		25. DATE RECD. BY LOCAL REG. APR 16 1960		26. REGISTRAR'S SIGNATURE Loard Smith, M.D. (H.T.)							

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 _____

Gayton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.