

FILED VS. SEP 21 1960

318

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>St. Louis MO.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <i>St. Louis MO.</i>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>None</i>		d. STREET ADDRESS (If outside, give location) <i>3127 Locust St.</i>	

3. NAME OF DECEASED (Type or print) First <i>Morgan</i> Middle <i>Autofield</i> Last <i>Morgan</i>			4. DATE OF DEATH Month <i>8</i> Day <i>26</i> Year <i>60</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (on birthday) <i>79</i>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	

13a. FATHER'S NAME <i>Wm. Morgan</i>		13b. MOTHER'S MAIDEN NAME <i>Wm. Morgan</i>		14. NAME OF HUSBAND OR WIFE <i>Wm. Morgan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Paul Morgan</i> (Address <i>1300 Clark St. St. Louis, Mo.</i>)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC</i>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <i>HEART DISEASE</i>			
DUE TO (c) <i>GENERALIZED ARTERIOSCLEROSIS</i>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>			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		
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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 <i>None</i> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 *9/30* to *9/30* and last saw her/him alive on *9/30*.
Death occurred at *Home* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Paul Morgan</i> (Degree or title) <i>Deputy Coroner</i>		22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9/3/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>9-30-60</i>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	23d. LOCATION (City, town, or county) <i>St. Louis, MO.</i>
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24. FUNERAL DIRECTOR <i>Rowland-Aker Mortuary</i> ADDRESS <i>4104 Manchester Ave.</i>	25. DATE RECD. BY LOCAL REG. <i>SEP 15 1960</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 2 1961

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. _____

P. O. Address _____

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.