

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-011294

XC-18095459 SL 24980

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2263**

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED VS. MAR 16 1961

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **915 N. GRAND, ST. LOUIS, MO.** Length of stay in 1b **9 DAYS**
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VETS. ADMIN. HOSPT.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** b. COUNTY _____
c. CITY OR TOWN **ST. LOUIS** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **5434 ST. LOUIS AVENUE** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **JOHN** Middle **HENRY** Last **MORGAN** 4. DATE OF DEATH Month **MARCH** Day **3** Year **1961**

5. SEX **MALE** 6. COLOR OR RACE **NEGRO** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **7/19/30** 9. AGE (last birthday) **30** 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) **PAINTER** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **ST. LOUIS, MISSOURI** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **WILLIE MORGAN** 13b. MOTHER'S MAIDEN NAME **MAGNOLIA WASHINGTON** 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) **YES KOREAN** 17. INFORMANT **MAGNOLIA MORGAN (MOTHER) SEE #2** Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **PERITONITIS**
DUE TO (b) **RUPTURED SUBPHRENIC ABSCESS**
DUE TO (c) **AMEBIC LIVER ABSCESS**
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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) **046.1**

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **2/22/61** to **3/3/61** and last saw him **live** on **3/3/61**
Death occurred at **9:30** pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree title) **Robert H. Farley M.D.** 22b. ADDRESS **VAH, ST. LOUIS, MO.** 22c. DATE SIGNED **3/4/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **3-10 -61** 23c. NAME OF CEMETERY OR CREMATORY **National Cemetery** 23d. LOCATION (City, town, or county) (State) **Jefferson Barracks, Mo.**

24. FUNERAL DIRECTOR **A.L. Beal Und.Co.** ADDRESS **4303 Delmar** 25. DATE RECD. BY LOCAL REG. **MAR 8 1961** 26. REGISTRAR'S SIGNATURE **Roan Smith, M.D.**

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

Arthur L. Hoellied

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.