

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 12 1940 **791**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **St. Louis, Missouri**
(a) County _____
(b) City or town _____
(c) Name of hospital or institution: **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **53 yrs. 9mo. 20days**
In this community _____ years, months or days

3. (a) PRINT FULL NAME **JOHN T. MORROW**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ethel Morrow** 6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **2-27-1886**
(Month) (Day) (Year)

8. AGE: Years **53** Months **9** Days **20**
If less than one day hr. _____ min. _____

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Paper cutter**

11. Industry or business _____
MOTHER FATHER { 12. Name **Charles Morrow**
13. Birthplace **Unknown**
14. Maiden name **Fannie Wilson**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **J. Deggen**
(b) Address **5400 Pershing St.**
17. (a) **Burial** (b) Date thereof **12-20, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **LANE CHARLES (EM.)**
18. (a) Signature of funeral director **Geo. L. Pleitsch Inc.**
(b) Address **5966-68 Easton Ave.**
19. (a) **DEC 10 1939** (b) **J. F. Baedrich**
(City, town, or county) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5085 Kensington Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **17**
year **1939** hour **5:02** minute **A.** M.
21. I hereby certify that I attended the deceased from **11-1-39**
that I last saw h. **1m** alive on **12-17-39**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Tabes Dorsalis (onset 1928x)**
Due to _____
Due to _____
Other conditions **Arteriosclerosis (1928x)**
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy **No**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **N. J. Buehler M.D.** (M. D. or other)
Address **5400 Pershing** Date signed **12-17-39**

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 3454

David C. Gibson

Registered Apprentice No.

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address

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 this body is not embalmed, above space should be left blank.