

No. 2
10-39
7-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27200
Registrar's No. 7096

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5417 Queens Ave. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 Years. years, months or days)

8. (a) PRINT FULL NAME Frances Morische. 1020

3. (b) If veteran, name war No. 8. (c) Social Security No. None.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Late John E. Morische. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 11 1859.
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 40 If less than one day _____ hr. _____ min.

9. Birthplace Illinois. (City, town, or county) (State or foreign country)

10. Usual occupation Housework.

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown.
18. Birthplace Unknown. 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown.
15. Birthplace Unknown. 9
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Morische.
(b) Address 5417 Queens Ave.

17. (a) Burial (b) Date thereof 8-24-40.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Zions cem.

18. (a) Signature of funeral director H. Leidner and Co.
(b) Address 2223 St. Louis Ave.

19. (a) AUG 22 1940 (b) J. F. Beck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County _____
(c) City or town St. Louis. 7
(If outside city or town limits, write "RURAL")
(d) Street No. 5417 Queens Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21
year 1940 hour 1: minute 00 P. M.

21. I hereby certify that I attended the deceased from Aug. 21 1940 to Aug. 21 1940
that I last saw her alive on Aug. 21 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) Ph

Major findings: Of operations _____
Of autopsy _____

Duration

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 Nancy E. Westerman (M. D. or other) M.D.
Address 2136 E. Grand Blvd Date signed 8/22/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

On western 2136 E Grand
1-3-7-8 P.M. No 5169

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John P. Bushholz

Licensed Embalmer No. 1674

P. O. Address 1223 St. Louis 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 this body is not embalmed, above space should be left blank.