

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. _____

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:
Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Hrs., 42 Min.**
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **Morgan**

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **D**

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

7. Birth date of deceased **2-1-41**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **3 hr. 42 min.**

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Morgan, Anna**

15. Birthplace **Hollysprings Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ether May Sherard**

(b) Address **2601 N. Whittier**

17. (a) **Burial** (b) Date thereof **2-27-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **Prof. Hamilton**

(b) Address **City Health Dept.**

19. (a) **SEP 26 1941** (b) **J. T. Grebeck**
(Date received for record) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **9** **11**
(d) Street No. **1713 Goode**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2** day **1**
year **1941** hour **4** minute _____ P. M.

21. I hereby certify that I attended the deceased from **2-1-** 19 **41** to **2-1-** 19 **41**
that I last saw him alive on **2-1-** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death **rematurity**

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy **As of above.**

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 **J. C. Peace** (M. D. or other) _____
Address **2601 N. Whittier** Date signed **2/24/41**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

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.