

S. No. 2  
M-5-43  
v. 5-17-39  
I X36871

13137

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 2 1944

Registration District No. 0-8

Primary Registration District No. 100

Registrar's No. 3708

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

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179

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
BARNES HOSPITAL O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 Days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret Morrow  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife John C. Morrow  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased October 29 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 5 21 hr. min.

9. Birthplace Lindsay Ontario 2  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name John Harrington

13. Birthplace Unknown Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Carroll

15. Birthplace Unknown Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant John K. Roedel

(b) Address Edwardsville, Ill.

17. (a) Removal (b) Date thereof 4-23-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Scotts Bluff, Neb.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 21 1944 (b) J. T. Bralock  
(Date funeral home registered) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison 999  
(c) City or town Edwardsville  
(If outside city or town limits, write "RURAL") N.R.  
(d) Street No. 504 N. Kansas  
(If rural, give location) O  
(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20<sup>th</sup>  
year 1944 hour 8 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 5, 1944 to April 20, 1944.  
that I last saw her alive on April 20, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Ht Disease & Coronary Occlusion

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy As 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 M. C. Abney (M. D. or other) \_\_\_\_\_  
Address BARNES HOSPITAL Date signed 4/21/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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

*Albert Hopper*

Licensed Embalmer No. *1861*

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, fact should be so stated above.**