

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22043

State File No.

FILED JUL 7 1949

BIRTH NO. _____ REG. DIST. NO. 17 PRIMARY REG. DIST. NO. 6026 Registrar's No. 1397

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Coverland</u>		b. COUNTY <u>St. Louis</u>	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Coverland</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>865 Argyle Ave</u>		d. STREET ADDRESS (If rural, give location) <u>8657 Argyle Ave.</u>	

3. NAME OF DECEASED (Type or Print) <u>SAMUEL SMITH MORGAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 9-49</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV. 25, 1875</u>	9. AGE (In years last birthday) <u>74</u>	10. IF UNDER 1 YEAR Months <u>6</u> Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (State or foreign country) <u>CAIRO, ILL.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>SAMUEL SMORGAN</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY ELLEN PUGH</u>		14. NAME OF HUSBAND OR WIFE <u>Ida MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES SPANISH AM.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Ida Morgan</u>	
ADDRESS _____					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary artery disease</u>		DUPLICATE				<u>2 wks</u>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Arterio-sclerosis</u>				<u>2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____				<u>4 1/2!</u> <u>94a</u>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			

22. I hereby certify that I attended the deceased from May 29, 1949, to June 9, 1949, that I last saw the deceased alive on June 9, 1949, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Maurice A. Bell M.D.</u>		23b. ADDRESS <u>89 1/2 St. Charles St. St. Louis, Mo.</u>		23c. DATE SIGNED <u>6/10/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/13/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE CEMETERY</u>	
24d. LOCATION (City, town, or county) (State) <u>LEMOORE, MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Baumann Bur. Inc.</u>		ADDRESS <u>2505 Woodson Rd. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-11-49</u>		REGISTRAR'S SIGNATURE <u>Thurmond Cunningham</u>			

WRITE PLAINLY—USING 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 3454

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Overland 14,

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.