

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6530

State File No.

1730

FILED MAR 4 1950

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ste. Genevieve	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Ste. Genevieve 0951	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED a. (First) Louis b. (Middle) A. c. (Last) Morice			4. DATE OF DEATH (Month) (Day) (Year) Feb. 19, 1950			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 21, 1884	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) River Aux Vasse, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Louis Morice		13b. MOTHER'S MAIDEN NAME Mary Louise LaLumandier		14. NAME OF HUSBAND OR WIFE Margaret Morice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Francis D. Morice, Ste. Genevieve, Mo.	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 mos
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pyelonephritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Reflexogenic Prostatic Retention DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Thrombosis of superior vena cava left axilla and glenoid artery		3 weeks	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) 610X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **1-23-1950** to **2-19-1950**, that I last saw the deceased alive on **2-19-1950**, and that death occurred at **10:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. M. Webb M.D. (Degree or title)	23b. ADDRESS 4501⁹ Manchester	23c. DATE SIGNED 2-21-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-20-50	24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Ste. Genevieve, Mo.		

DATE REC'D BY LOCAL REG. FEB 22 1950	REGISTRAR'S SIGNATURE J. B. Leater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. H. ppe, 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 7 1950

MAR 30 1950

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed William S. Dalton

Licensed Embalmer No. 4699

P. O. Address St. Charles Mo.

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.