

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19089

State File No.

FILED JUN 14 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5030**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) ST LOUIS		c. LENGTH OF STAY (in this place) c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 314 LACLEDE AVE		STREET ADDRESS (If rural, give location) 290314 LACLEDE AVE.	
3. NAME OF DECEASED a. (First) MRS. SARAH (Type or Print)		b. (Middle) MORGAN c. (Last)	
5. SEX FEMALE		6. COLOR OR RACE NEGRO	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 4-6-1899	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	
11. BIRTHPLACE (City and State or Foreign Country) CLARKSDALE MISS.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME MATTIE UNKNOWN	
14. NAME OF HUSBAND OR WIFE LISTON MORGAN (DECEASED)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT'S SIGNATURE OR NAME Rose Hill ADDRESS 3141 Laclede	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 434.1	
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)	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 345A m., from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 1200 Glen. S	
23c. DATE SIGNED 5/29/57		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE 6-4-57		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MO.		25. FUNERAL DIRECTOR'S SIGNATURE Bennie Love ADDRESS 3103 Washington	
DATE REC'D BY LOCAL REG. MAY 29 57		REGISTRAR'S SIGNATURE [Signature]	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. CLAUDE GORDON

Licensed Embalmer No. 348

P. O. Address 4575 ALDIN

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.