

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37890

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9439

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.#1.		d. STREET ADDRESS (If outside, give location) 2210 2 143 0' FALLON	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY MORRIS		4. DATE OF DEATH Month Day Year OCT. 2, 1957	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 18 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) NONE ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME MAE ELLEN MORRIS	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST. LOUIS CITY HOSP.#1.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarrhea</u> DUE TO (b) <u>Micrococcus aureus</u> DUE TO (c) <u>764.5</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Immaturity</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9/14/57 to 10/2/57 and last saw her/him alive on 10/2/57 Death occurred at 6:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ray C. Case M.D.</u>		22b. ADDRESS 1515 LAFAYETTE AVE.	
22c. DATE SIGNED 10/2/57		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE 10-31-57		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		24. FUNERAL DIRECTOR Newland - Aker 4104 Manchester	
25. DATE RECD. BY LOCAL REG. OCT 10 1957		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

10/31/21

10/31/21

Licensed Embalmer No.

P. O. Address

10/31/21

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.