Health, Welfare Public Service

. 300
1-56 0

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 48534-58

58-030781
STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7694

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ralls
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN New London — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Glennon Memorial Hospital — Length of stay in Hospital	d. STREET ADDRESS (If outside, give location) Route 1 — Reside on Farm Yes X No ☐

3. NAME OF DECEASED (Type or print)	First: Elizabeth	Middle: Ann	Last: Morrison	4. DATE OF DEATH	Month: Aug.	Day: 5	Year: 1958
5. SEX: Female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: July 18, 1958	9. AGE (In years last birthday): 19	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): None	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country): Hannibal, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Wayne R. Morrison			14. MOTHER'S MAIDEN NAME: Bonnie Lake				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.: None	17. INFORMANT: Wayne Morrison,	Address: Hannibal, Mo.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningomyelocoel
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arnold Chiari Syndrome
DUE TO (c) 753.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 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 7-18- to 8-5- and last saw her/him alive on 8-5-58
Death occurred at 11:25 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
John D. Bonham MD	Cardinal Glennon Hospital	8-7-58

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	8-6-58	New Salem Cemetery	Ralls Co., Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Albert H. Hoppe	4700 Washington Blvd.	AUG 7 '58	Earl Smith MD MDK

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, ~~or by~~....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 42

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.