DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-042573
STATE FILE NUMBER

ED VS NOV 28 1960 Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 127

1. PLACE OF DEATH
a. COUNTY: JEFFERSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: RURAL - MERAMEC
Length of stay in 1b: 1 MO. 1 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. JOSEPH'S HILL INFIRMARY
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MO.
b. COUNTY: ST. LOUIS
c. CITY OR TOWN: CLAYTON
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 445 CARRSWOLD DR.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JOSEPH Middle: E. Last: MORRISON

4. DATE OF DEATH Month: NOVEMBER Day: 7 Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. Married ☐ **Never Married** ☐ **Widowed** ☒ **Divorced** ☐

8. DATE OF BIRTH: 7-9-1871

9. AGE (last birthday): 89

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: LAWYER

11. BIRTHPLACE (City and state or country): CHICAGO, ILL.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: ALEXANDER L. MORRISON

13b. MOTHER'S MAIDEN NAME: JANE CLARK

14. NAME OF HUSBAND OR WIFE: LATE HOLLIS MORRISON UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: BROTHER LEONARD. Address: ST. JOSEPH'S HILL INFIRMARY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic hypertensive cardiovascular
DUE TO (c): disease.
INTERVAL BETWEEN ONSET AND DEATH: 2 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 Dec 1959 to 11-7/60 and last saw her/him alive on 11/2/1960.
Death occurred at 3:22 pm 11/7/60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Patrick C. Hogan MD

22b. ADDRESS: 2623 Telegraph Rd Lemay

22c. DATE SIGNED: 11/7/60.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: NOV. 10 1960

23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM

23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR: KRIEGSHAUSER

ADDRESS: 9450 OLIVE ST. RD

25. DATE RECD. BY LOCAL REG.: 11-10-60

26. REGISTRAR'S SIGNATURE: Robert E. Bauer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Richard W Storey

Signature of Student Embalmer

Licensed Embalmer No. 4007

P. O. Address St Lou

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