

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013609

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 757

FILED MAR 19 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS</b>		Length of stay in 1b <b>137 DAYS</b>	c. CITY OR TOWN <b>CLAYTON</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7727 WYDOWN</b>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>C</b> Last <b>MORFIT</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>3</b> Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SURGEON</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICAL PROFESSION</b>	9. AGE (last birthday) <b>87</b>
11. BIRTHPLACE (City and state or country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>MASON MORFIT</b>		13b. MOTHER'S MAIDEN NAME <b>ELIZABETH GARRISON</b>	14. NAME OF HUSBAND OR WIFE <b>SALLY MORFIT</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>SALLY MORFIT, WIFE, 7727 WYDOWN, CLAYTON, MISSOURI</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. ARTERIOSCLEROTIC HEART DISEASE 2. GENERALIZED ARTERIOSCLEROSIS</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <u>10-17-61</u> to <u>3-3-62</u> Death occurred at <u>8:38 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert W. Deane</i> MD		22b. ADDRESS <b>VAH JEFFERSON BARRACKS, MO.</b>	22c. DATE SIGNED <b>3-3-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3-5-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>VALHALLA CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Co. Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C.R. LUPTON &amp; SONS - 7233 DELMAR-</b>		25. DATE RECD. BY LOCAL REG. <b>3-5-62</b>	26. REGISTRAR'S SIGNATURE <i>John G. Murphy</i>

USE BLACK INK OR TYPEWRITER RIBBON

**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

*C. Lawrence A. Murray*

Licensed Embalmer No. 4011

P. O. Address St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.