MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. □ AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cape Girardeau

Township or Village: ~~Cape Girardeau~~

or City: Cape Girardeau (NO. ..... St.: ..... Ward)

Registration District No. 125

Primary Registration District No. 3009

File No. 27012

Registered No. 1235

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Charles Morison

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR ~~OR RACE~~: White

SINGLE ~~MARRIED~~ WIDOWED OR DIVORCED (Write the word): Divorced Widowed

DATE OF BIRTH: Feb (Month) Feb (Day) 11, 1871 (Year)

AGE: 44 yrs. ..... mos. ..... ds.

IF LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer 22
(b) General nature of industry, business, or establishment in which employed (or employer): Tie Carrier 186B

BIRTHPLACE (City or town, State or foreign country): Cape County

PARENTS
NAME OF FATHER: Geo. Morison
BIRTHPLACE OF FATHER (City or town, State or foreign country): U. S
MAIDEN NAME OF MOTHER: Mary Cooke
BIRTHPLACE OF MOTHER (City or town, State or foreign country): U. S

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Dave Cook

(ADDRESS): R 7 D #2 Cape Gir. Mo

Filed Sept 12, 1915. R. W. Fussell, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept. (Month) 11 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 10, 1915, to Sept 11, 1915, that I last saw him alive on Sept 11, 1915, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tetanus —
Infection through Crushing injury of left hand
accidental (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY): Crushing Injury
Tetanus (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Portuguese Jr. M. D.

Sept 11, 1915 (Address) Cape Girardeau Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Shady Grove

DATE OF BURIAL: Sept 12, 1915

UNDERTAKER: S E Mo. Und Co

ADDRESS: Cape Gir Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... F[redacted]

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City .....(NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191.....; and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration)..... yrs. ..... mos. ..... ds.

Contributory .....
(SECONDARY)

.....(Duration)..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING