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.

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

PLACE OF DEATH

County Pettis

Township or Village or City Sedalia (NO. M.K.&T. Ry Hosp. St.; 3d Ward)

Registration District No. 668 File No. 38282

Primary Registration District No. 3032 Registered No. 316

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

FULL NAME David Elmer Morris

PERSONAL AND STATISTICAL PARTICULARS

SEX male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

DATE OF BIRTH Nov — (Month) (Day), 1876 (Year)

AGE 39 yrs. mos. ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Bridge Gang

BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS
NAME OF FATHER David Morris
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Katherine Letherman
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. W. Morris

(ADDRESS) Oswego Kansas

Filed Dec. 24, 1915 F. B. Posey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 24 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 17, 1915, to Dec 24, 1915, that I last saw him alive on Dec 24, 1915, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

108

6 days (Duration) yrs. mos. ds.

Contributory (SECONDARY) None

(Duration) yrs. mos. ds.

(Signed) C. S. McGinnis M. D.

12-24, 1915 (Address) Sedalia 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 Parsons Kansas

DATE OF BURIAL Dec. 26, 1915

UNDERTAKER McLaughlin B.

ADDRESS Sedalia

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO. .... St.:.....Ward)

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

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

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

FULL NAME.....

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.

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

.....(Month) .....(Day), *19*.....(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

.....(Month) .....(Day), *191*.....(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