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 10337

Registration District No. 418 File No. 1 10061

Primary Registration District No. 5572 Registered No. 37

1 PLACE OF DEATH

County Jasper

Township or Village Mendon

City (NO. , St., Ward)

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

2 FULL NAME Paul Estel Morrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Child

6 DATE OF BIRTH: Dec 19, 1918 (Month) (Day) (Year)

7 AGE: X yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Jasper Co Mo.

PARENTS

10 NAME OF FATHER: L. S. Morrison

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.

12 MAIDEN NAME OF MOTHER: Rosa Bower

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. S. Morrison
(Address) Mendon Mo

15 Filed 4-10-, 1919 W. O. Coleman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 29th, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 24, 1919, to March 29th, 1919, that I last saw him alive on March 29th, 1919, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

1076

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. A. Carlyle M. D.

March 30th, 1919 (Address) Aldna Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Mendon Mo — DATE OF BURIAL: 3/30, 1919

20 UNDERTAKER: Hall City Und Co — ADDRESS: Hall City Mo

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH: ....., 1..... (Month) (Day) (Year)

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
....., 191.....
(Month) (Day) (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 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.