

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

Do not use this space.

16958

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
City (No. **2731**, **Adams**)

File No.....
Registered No. **4919**
St. Ward)

2. FULL NAME

(a) Residence. No. **Efrom Morgan**
(Usual place of abode) **2731 Adams St. 22** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** | 4. COLOR OR RACE **col** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **unknown**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt 31

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Laborer**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Columbus Miss**
(STATE OR COUNTRY)

10. NAME OF FATHER **Ellis Morgan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Miss**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mary Harris**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Miss**
(STATE OR COUNTRY)

14. INFORMANT **Mattie Morgan**
(Address) **2731 Morgan**

15. FILED **MAY 25 1927** **Marie Stahcock**
19..... REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-20 1927**

17. I HEREBY CERTIFY, That I attended deceased from **May 13 1927** to **May 20 1927** that I last saw **her** alive on **May 20 1927**, and that death occurred, on the date stated above, at **7:30 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108 10/10 (duration) yrs. mos. **8** ds.
CONTRIBUTORY **Lobar Pneumonia** (SECONDARY) (duration) yrs. mos. **8** ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH..... **unknown**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Symptoms**
(Signed) **L. J. Vincent**, M. D.
, 19 (Address) **239 1/2 So. Jefferson**

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Washington Pk.** DATE OF BURIAL **5/25/27 19**

20. UNDERTAKER **Peoples and Co.** ADDRESS **13120 Franklin**

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.

