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

Do not use this space.

18014

File No. .....

Registered No. 359

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township ..... — Primary Registration District No. 2001

City Springfield (No. 1505 N. Missouri St. ..... Ward)

2. FULL NAME Martha Ann Morris

(a) Residence. No. 1505 N Missouri St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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

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

JUN 26 1927

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: F. M. Morris

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 6 1846

7. AGE: Years 81 | Months 1 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Stephen Bridges

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

12. MAIDEN NAME OF MOTHER Elizabeth Ross

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

14. INFORMANT Joe Morris
(Address) Springfield Mo.

15. FILED 6/12 1927 O. C. Forst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan ....., 1926, to ....., 1927, that I last saw her alive on May 1 1927, and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
8 A Cerebral Hemorrhage
7 Hrs
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. E. Cox, M. D.
6/12 1927 (Address) 223½ South

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Green Lawn Cemetery — DATE OF BURIAL: June 12 1927

20. UNDERTAKER: J. P. Klingner & Co — ADDRESS: 424 E. Commercial St. Springfield Mo