AUG 17 1927

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

Do not use this space.

21881

1. PLACE OF DEATH

County: Linn — Registration District No.: 496 — File No.:

Township: — Primary Registration District No.: 3025 — Registered No.: 56

City: Brookfield (No. 223- S. Monroe St. 3 Ward)

2. FULL NAME: Diella L. Morgan

(a) Residence. No. 223 S. Monroe St., 3 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F.	W.	Married

5a. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF: Dan. Morgan

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1-23 1883

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
44	5	26	

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): Linn County
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Geo. W. Linebarg
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Not Known
(STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Eliza Pucciam
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Not Known
(STATE OR COUNTRY): " "

14. INFORMANT: Dan. Morgan
(Address): Brookfield Mo

15. FILED 7-22, 1927. Bessie M. Fox, Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-19- 1927

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1927, to July 19, 1927, that I last saw him alive on July 19, 1927, and that death occurred, on the date stated above, at 2:32 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction
12.2.B
12.9 (duration) yrs. mos. 7 ds.

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

18. WHERE WAS DISEASE CONTRACTED: Home
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF July 18, 1927
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed): P. M. Smith, M.D.
, 19 (Address): Brookfield Mo

*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: Rose Hill — DATE OF BURIAL: 7-22 1927

20. UNDERTAKER: C. Wyatt — ADDRESS: Brookfield

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
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Linn — Registration District No. 496 — File No.

Township — Primary Registration District No. 3825 — Registered No. 56

City Brookfield (No. ..... St. ..... Ward)

2. FULL NAME Della L. Morgan

(a) Residence. No. ..... 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 7-22, 1927 Bessie M. Fore Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction

Adhesion from operation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Peritonitis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 118B2

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) F. M. Smith D.O., M.D.

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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