

MAY 24 1929

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

Do not use this space.

14211

1. PLACE OF DEATH

County *Clinton*

Registration District No. *107*

File No. *17*

Township

Primary Registration District No. *4175*

Registered No. *17*

City *Plattsburg* (No. ....) St. .... Ward)

2. FULL NAME

*Daniel Webster Mourse*

(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 *45* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 27, 1867*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
*61 8 7*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *carpenter*  
(b) General nature of industry, business, or establishment in which employed (or employer) *and meat Market*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs. Priscilla Mourse* (Address) *Plattsburg Mo*

15. FILED *4/8 29* REGISTRAR *[Signature]*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 4 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Mar 29*, 1929, to *April 4*, 1929, that I last saw *h. 29* alive on *April 4*, 1929, and that death occurred, on the date stated above, at *Plattsburg Mo*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Acute Prostatitis*  
*930*  
*1051* (duration) ... yrs. *3* mos. ... ds.

CONTRIBUTORY (SECONDARY) *Myocarditis* (duration) ... yrs. ... ds.

18. WHERE WAS DISEASE CONTRACTED *At home*  
NOT AT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH? *No* DATE OF ...  
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical symptoms*  
(Signed) *U. B. Spalding* M. D.  
*Apr. 6, 1929* (Address) *Plattsburg 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 *Plattsburg Mo* DATE OF BURIAL *4-6 1929*

20. UNDERTAKER *Basile Nelson* ADDRESS *Plattsburg Mo*

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.

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