MAR 27 1930

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

Do not use this space. 960 54 9 (4)

1. PLACE OF DEATH

County Howell — Registration District No. 384 — File No.

Township — Primary Registration District No. 4227 — Registered No.

City West Plains (No. ..., ... St. ..... Ward)

2. FULL NAME Mrs. Cecil Beatrice Jones Morrison.

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 21, 1905

7. AGE: 24 YEARS, 2 MONTHS, 9 DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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): Koshkonong, Missouri

PARENTS
10. NAME OF FATHER: Charles Jones
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Thayer, Missouri
12. MAIDEN NAME OF MOTHER: Laura Jones
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Koshkonong, Missouri

14. INFORMANT: Mrs. Charles Jones
(Address): Koshkonong, Mo

15. FILED 1-31-1930 O. P. A. Heinrich, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 30th 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22nd, 1929, to Jan. 30th, 1930, that I last saw her alive on Jan 29th, 1930, and that death occurred, on the date stated above, at 8:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-pneumonia, Delayed resolution.
25A
1026 (duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (SECONDARY): Tuberculosis, chronic Pulmonary. (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. H. Thornburgh, M. D.
1/30, 1930 (Address) West Plains, 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: Koshkonong, Mo.
DATE OF BURIAL: Feb 1, 1930

20. UNDERTAKER: Hal Thornburgh
ADDRESS: West Plains Missouri

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.