

MAR 25 1930

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. St. Joseph Hospital)

File No. 4186
Registered No. 257
St. _____ Ward _____

2. FULL NAME Louis Morgan

(a) Residence No. _____ St. _____ Ward Kellerton Iowa
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 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 B. E. Morgan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8, 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or ms.
53 7 19 00

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) own home
(c) Name of employer _____

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

10. NAME OF FATHER J B Stark

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

12. MAIDEN NAME OF MOTHER Mary Burris

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

14. INFORMANT B. E. Morgan
(Address) Kellerton Iowa

15. FILED Feb 28 1930 John G. W. REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 27, 1930, that I last saw h. OT alive on _____, 19____, and that death occurred, on the date stated above, at 11/45 P m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Abscess of Temporal Lobe
due to meningitis
abscess (duration) _____ yrs. mos. 2 ds.

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

18. WHERE WAS DISEASE CONTRACTED Kellerton Ia.
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS Spinal & Cerebral
(Signed) Carl Keller M. D.

Feb. 28. 19 30 (Address) 731 Taron

*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 Kellerton Iowa DATE OF BURIAL Mar. 2 1930

20. UNDERTAKER Phil Sidenfaden ADDRESS 1802 Union St.

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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