

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

Do not use this space.

15747

1. PLACE OF DEATH
 County Dent Registration District No. 266
 Township _____ Primary Registration District No. 4124
 City Salem (No. _____) St. _____ (Ward) _____
 2. FULL NAME Walter Oliver Morton
 (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 9 yrs. 6 mos. ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. ds.

File No. _____
 Registered No. 113
 St. _____ (Ward) _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2 - 1897

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>33</u>	<u>1</u>	<u>2</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Monticello
 (STATE OR COUNTRY) Dent Co Mo.

10. NAME OF FATHER David A Morton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dent Co Mo.
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Ida A Beard

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

14. INFORMANT Wm D. W. Morton
 (Address) Salem, Mo.

15. FILED 5/6 1930 W. E. Ridd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1930

17. I HEREBY CERTIFY that I attended deceased from August 25 1929 to May 5 1930 that I last saw him alive on May 5 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23 A
23 B (duration) _____ yrs. _____ mos. ds.

CONTRIBUTORY (SECONDARY) Pulmonary Infarction
 (duration) _____ yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? usual physical
 (State) Mo St. Mary's M. D.
 , 19 _____ (Address) Salem Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Toxas Co DATE OF BURIAL 5/6 1930

20. UNDERTAKER N. D. Hobbs ADDRESS Salem Mo

RECORD PERMANENTLY 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.

FILED FOR BIRTH

