OCT 31 1930

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

Do not use this space.

File No. 30917

Registered No. 17

1. PLACE OF DEATH
County: St Clair
Township: Osceola
City: Osceola (No. ..... St. ..... Ward)
Registration District No. 765
Primary Registration District No. 4460

2. FULL NAME: Lester Eugene Morgan

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 27th 1930

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	14	

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): at home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Osceola
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Walter Morgan
11. BIRTHPLACE OF FATHER (CITY OR TOWN): St Clair Co
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Thelma Kong
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Mo

14. INFORMANT: H T Morgan
(Address): Osceola Mo

15. FILED 10/1 1930 Ruth Secrest
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug ....., 19..., to Sept 26, 1930, that I last saw h. alive on Sept 26, 1930, and that death occurred, on the date stated above, at 10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Summer complaint and malarial fever
..... (duration) ..... yrs. ..... mos. ..... ds.

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

1133

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? none
(Signed) H D Dalgleish, M. D
9/27, 1930 (Address) Osceola 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: Durand Cemetery
DATE OF BURIAL: Sept 27 1930

20. UNDERTAKER: McCluney - Austin
ADDRESS: Osceola Mo

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.