

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

Do not use this space.

9871

1. PLACE OF DEATH

County Jackson
Township Clare
City Academy (No. 1316 E 33)

Registration District No. 399
Primary Registration District No. 100

File No. 1137
Registered No. 1137
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1316 E 33 St. 13 Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 6 7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto Livery
(b) General nature of industry, business, or establishment in which employed (or employer) 16
(c) Name of employer

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

10. NAME OF FATHER James Morrow

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

12. MAIDEN NAME OF MOTHER Mary Bernell

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

14. INFORMANT Lillian Morrow
(Address) 1316 E 33

15. FILED 3/9 1931 M.M. Craves REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 1931

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1931, to March 9, 1931 that I last saw him alive on March 7, 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic bronchitis with emphysema
hypertrophy of right ventricle
cardiac degeneration
many years (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) arterio-sclerosis
many years (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 930
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS neuropath
(Signed) A. Miller, M. D.

(Address) 717 Shubert Bldg

*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 Forest Hill DATE OF BURIAL 3-11-31

20. UNDERTAKER Mrs. C. L. Foster ADDRESS F.C. 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.

