

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

Do not use this space.

23665

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1008**
No. **Deposition Hosp**

File No.
Registered No. **7184**
St. Ward)

2. FULL NAME

(a) Residence. No. **1414 Wagoner** St., **4** Ward. **Clinton Mo**
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. **2** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Anna St. J. Morten**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **1-13-1844**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 5 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Physician 213**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Union** (STATE OR COUNTRY) **Ohio**

10. NAME OF FATHER **Hy Morten**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Union** (STATE OR COUNTRY) **Ohio**
12. MAIDEN NAME OF MOTHER **Elizabeth Spencer**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Union** (STATE OR COUNTRY) **Ohio**

14. INFORMANT **L. H. Morten** (Address) **#1414 Wagoner St. Clinton Mo**

15. FILED **30** 19**31** REGISTRAR **L. H. Morten**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-29 1931**

17. I HEREBY CERTIFY, That I attended deceased from **6-27 1931** to **6-29 1931** that I last saw **h. 12** alive on **6-29 1931** and that death occurred, on the date stated above, at **5:40 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile
152 **several** (duration) yrs. mos. ds.
CONTRIBUTORY **Arterio-sclerosis** (SECONDARY) **Several** (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

20. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Richard H. Spencer** M.D.

, 19 (Address) **7181 Hammond St. Clinton 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 1 DATE OF BURIAL
Valley Cemetery Ohio **6/30 1931**

20. UNDERTAKER **Alexander & Sons** ADDRESS **6175 Kewanee**

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.

