

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

Do not use this space.

8052

1. PLACE OF DEATH

39 County Greene Registration District No. 317
Township Wilson Primary Registration District No. 5442
City (No. Missouri) St. _____ Ward _____

2. FULL NAME William A. Morrison

(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 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 Widowed
(write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jula E. Morrison
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 5 - 1843
7. AGE 89 YEARS MONTHS 1 DAYS 16 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spliner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Tenness (STATE OR COUNTRY) 3

MOTHER 13. NAME Goal Morrison

14. BIRTHPLACE (CITY OR TOWN) 31 (STATE OR COUNTRY)

15. MAIDEN NAME Martha Waters

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT Mrs. J. Burlson (ADDRESS) Clear Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wash Hill DATE Mar 23 1932

19. UNDERTAKER F. W. Maples (ADDRESS) Clear Mo

20. FILED 3/21 1932 W. W. Shover Registrar.

MEDICAL CERTIFICATE OF DEATH

2
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/21 1932
22. I HEREBY CERTIFY, That I attended deceased from 2-18 1931 to 2-20 1932
I last saw him alive on 2-20 1932 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Indigestion
11B
11B 16R
Other contributory causes of importance: Fracture (D)
Date of onset

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) Henry J. Kealey M. D.
(Address) 4504 E. Council St.

5189 mo

WHITE PAPER, WITH 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.

