

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.

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

Do not use this space.

340

1. PLACE OF DEATH
 County Scott Registration District No. 1151
 Township _____ Primary Registration District No. 4588
 City Loufelle-mo (No. _____) St. _____ Ward _____
 2. FULL NAME George Morris
 (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.

File No. 22851
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>✓</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1861</u>		
7. AGE YEARS <u>73</u>	MONTHS	DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Revis worker</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>✓</u>	
	10. Date deceased last worked at this occupation (month and year) _____	
11. Total time (years) spent in this occupation _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____		
FATHER	13. NAME <u>Hugh Morris</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____	
MOTHER	15. MAIDEN NAME _____	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____	
17. INFORMANT <u>Melissa Speaks</u> (ADDRESS) <u>Loufelle-mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Kelso Cemetery</u> DATE <u>June 24, 1934</u>		
19. UNDERTAKER <u>P. C. Crowell</u> (ADDRESS) <u>Loufelle-mo</u>		
20. FILED <u>6. 21. 1934</u> <u>34407</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24, 1934
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 3:40 a.m.
 The principal cause of death and related causes of importance were as follows:
Paralytic
apoplexy
of the brain
 Other contributory causes of importance: _____
 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) Hugh Morris
 (Address) Loufelle-mo

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: George Morris
Who died at _____ on June 24, 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years 73 Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Paralysis Cerebral Hemorrhage

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar HTH Coy Date filed 4/24/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McLaugh
M. n

Special Agent.

Reg. Dist. No. 115-1

Primary Reg. Dist. No. 4588

