

APR 2 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

7917

1. PLACE OF DEATH

County MonroeRegistration District No. 1057Township GalleyPrimary Registration District No. 6214City Barrett (No.)St. Ward 2. FULL NAME Billie Harold Morin(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 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 8 1934

7. AGE

YEARS

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. Infant9. 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) (STATE OR COUNTRY) Barrett Mo.13. NAME Paul Morin14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pickering Mo.15. MAIDEN NAME Lyble Carroll16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grant City Mo.17. INFORMANT (ADDRESS) Paul Morin Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Grant CityDATE 2/11/3519. UNDERTAKER (ADDRESS) Arch C. Dymally Grant City Mo.20. FILED Feb 15, 1935Reg. O. H. Bond

Registrar.

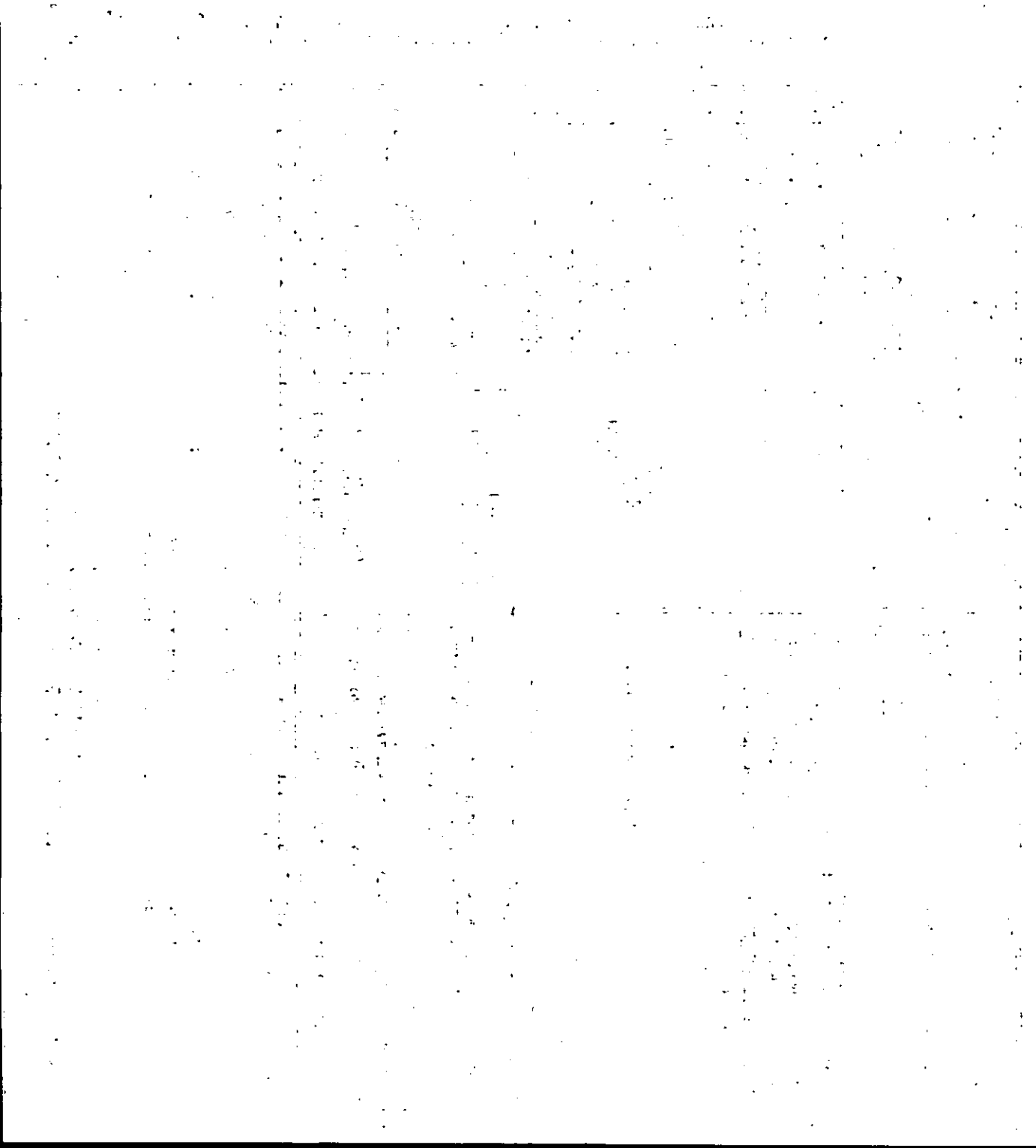
MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 9 193522. I HEREBY CERTIFY, That I attended deceased from Feb 7 1935 to Feb 9 1935I last saw him alive on Feb 9 1935. Death is said to have occurred on the date stated above, at 5:08 p.m.

The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia Date of onset Feb 5Other contributory causes of importance Name of operation Date of What test confirmed diagnosis Physician's findings Was there an autopsy? Yes23. 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? YesIf so, specify (Signed) J. Hass M. D.(Address) Grant City 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.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County North
Township Green
City _____ (No. _____)

Registration District No. 105-7
Primary Registration District No. 6-214

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

2. FULL NAME

Billie Harold Morris

(a) Residence, No. _____ St. _____ 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 w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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, months, days) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED Feb 15 1935 - Mrs O. H. Bond Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 9 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him alive on _____ 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: Bronchial Pneumonia Date of onset _____

Other contributory causes of importance: There was nothing else such as your asking just Bronchial Pneumonia

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) _____, M. D. (Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MAY 8 1964

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