

1939 APR 13 1939

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

12529
Do not use this space.

1. PLACE OF DEATH ²
 (a) County Stoddard Registration District No. 838
 (b) Township Deputy Primary Registration District No. 4519
 (c) City Deputy Mo (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Ellen Morrison
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBANDS OF (OR) WIFE OF H.E. Morrison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-5-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
74 1 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 5 yrs. 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Transisco, Ind.

FATHER 13. NAME Geo. W. Ferick
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Patsy Smith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) H.E. Morrison Deputy Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Depta DATE 3-15-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins Funeral Depta Mo

20. FILED 4/11 1939 Jennie Burton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from MOB-13- 1939 to MOB-15- 1939
 I last saw h. alive on MOB-13- 1939. Death is said to have occurred on the date stated above, at 4:20 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Sclerosis
87 lb
 Other contributory causes of importance: Senility

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? No
 If so, specify _____
 (Signed) Frank LaRue, M. D.
 (Address) Depta Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. E.—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.

30M-9-19-38 I X16953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

William C. Shelton....., Registered Apprentice No.....
working under my personal supervision.

Signed *William C. Shelton*.....

Licensed Embalmer No. *3929*.....

P. O. Address *Dexter, Mo.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

21-40
X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12529-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No. Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Dexter
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community named (Specify whether years, months or days)

3. (a) PRINCE FULL NAME Mary E. Morrison
 (b) If veteran, name war
 (c) Social Security No.

4. Sex 7 5. Color or race w
 6. (a) Single, widowed, married, divorced m
 (b) Name of husband or wife
 (c) Age of husband, or wife, if alive, years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name
 { 13. Birthplace (City, town, or county) (State or foreign country)
 { 14. Maiden name
 { 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
 (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation

18. (a) Signature of funeral director
 (b) Address

19. (a) 4/11 1939 (b) Jessie Burston
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State (b) County
 (c) City or town (If outside city or town limits write "RURAL")
 (d) Street No. (If rural, give location)
 (e) If foreign born, how long in U. S. A. years

20. DATE OF DEATH Month Mar. 15 - 1939 -
 year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
 that I last saw him alive on
 and that death occurred on the date and hour stated above.
 Immediate cause of death
Cerebral Sclerosis
Arterio Sclerosis
of cerebral & meningeal
blood vessels.
Remedy

Due to
 Due to
 Other conditions (Include pregnancy within 3 months of death) 99

Major findings:
 Of operations
 Of autopsy

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? (Specify type of place) (e) Means of injury

23. Signature Frank LaRue (M. D. or other)
 Address Date signed

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

