

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.

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

22098
Do not use this space

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
 (b) Township SPRINGFIELD Primary Registration District No. 1001
 (c) City SPRINGFIELD or (d) Street No. Bapst. Hosp. St.
 (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.

Registered No. 451

2. PRINT FULL NAME Ida Belle Morgan

(a) Residence, No. Waynesville, Mo. 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 HUSBAND OF (OR) WIFE OF J.B. Morgan
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 24, 1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 6 7
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Waynesville 0
 (STATE OR COUNTRY) Missouri 1

FATHER 13. NAME James Rollins 1

14. BIRTHPLACE (CITY OR TOWN) Virginia 1
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Gallie Martin

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

17. INFORMANT Dr. J.E. Rayl
 (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Waynesville, Mo. DATE June 2, 1939

19. FUNERAL DIRECTOR (NAME) H.H. Lohmeyer
 (ADDRESS) Springfield, Mo. 296

20. FILED 6-2 1939 Chas. George MD
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 26, 1939, to 6/1, 1939
 I last saw her alive on June 1, 1939 Death is said to have occurred on the date stated above, at 5 p.m.
 The principal cause of death and related causes of importance were as follows:

Myocarditis, Cr. Date of onset late 1938
Choluria
and
Ascites
 Other contributory causes of importance: Choluria & Ascites

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) Ray D. Callaway, M.D.
 (Address) Springfield, Mo.

MAR 12 1945

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed M. L. Casaday

Licensed Embalmer No. 3434

P. O. Address Springfield,

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.

X