

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

40080  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jefferson Registration District No. 460  
 (b) Township Jeffersonville Primary Registration District No. 427A  
 (c) City Jeffersonville (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 Margaret Ann Morris  
 (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 HUSBAND OF (OR) WIFE OF John Morris

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 2, 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>55</u>	<u>3</u>	<u>22</u>	

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) (STATE OR COUNTRY) Jeffersonville; Mo

FATHER

13. NAME Henry Siegfried 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany 6

MOTHER

15. MAIDEN NAME Ann Fox 9

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

17. INFORMANT Marvin Morris  
(ADDRESS) Blairville, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Methodist Church DATE Nov 25, 1939

19. FUNERAL DIRECTOR (NAME) E. J. Jones  
(ADDRESS) Conradia, Mo.

20. FILED Nov 20, 1939 of Paul Webb  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1939, to Nov 24, 1939  
 I last saw him alive on Nov 24, 1939. Death is said to have occurred on the date stated above, at 11:45 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma - of breast with metastases & generalized carcinomatosis

Date of onset Sept '38

Other contributory causes of importance: 50

Name of operation Radical mastectomy Date of Dec 1938  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

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) O. J. Jessell \_\_\_\_\_, M. D.  
 (Address) Russell St. Jeffersonville Mo

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 12/5/39

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 E. S. James  
Licensed Embalmer No. 2058  
P. O. Address Commodia

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.