

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

42755
Do not use this space.

1. PLACE OF DEATH
 (a) County Boone Registration District No. 73
 (b) Township Columbia Primary Registration District No. 3006
 (c) City Columbia (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 ELLA MORRISON
 (a) Residence, No. 406 PARK AVE. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF King Morrison
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-1-1870
 7. AGE YEARS 69 MONTHS 3 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 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 (STATE OR COUNTRY) Missouri
 13. NAME Thomas Hawkins
 14. BIRTHPLACE (CITY OR TOWN) Don't know (STATE OR COUNTRY) _____
 15. MAIDEN NAME Don't know
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) Francis Williams
Columbia Missouri
 18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE 12-15-1939
 19. FUNERAL DIRECTOR (NAME) Stewart O. Parker (ADDRESS) Columbia, Missouri
 20. FILED 12/13/39 Allie Selby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-12-39 19
 22. I HEREBY CERTIFY, That I attended deceased from 12-10-39 to 12-12-39, 19
 I last saw him alive on 12-12-39, 19. Death is said to have occurred on the date stated above, at 10:45am.
 The principal cause of death and related causes of importance were as follows:
Central Hemorrhage
Paralysis
 Other contributory causes of importance: JW
 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) Da Moon, M. D.
 (Address) 301 N. 5th Columbia 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.

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~~.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Stuart P. Parker

Licensed Embalmer No. *2900*

P. O. Address *Columbia, N.Y.*

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.