

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

JUL 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21779

Registration District No. 944

Primary Registration District No. 5447-B

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Strafford, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural Jackson township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural - Jackson township
(If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME ELIZABETH MORTON 1235

3. (b) If veteran, X name war _____ 3. (c) Social Security No. X

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sam 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Nov. 14 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 23 If less than one day hr. X min.

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

10. Usual occupation Housewife

11. Industry or business X

MOTHER { 12. Name Geo. Creson
13. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Elizabeth Foster
15. Birthplace N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Roma Morton

(b) Address Marshfield, Missouri

17. (a) Danforth (b) Date thereof 11-9-40
(Burial, ~~cremation~~) (Month) (Day) (Year)

(c) Place: burial or cremation Danforth

18. (a) Signature of funeral director Rev. H. H. Hays
(b) Address Marshfield, Mo.

19. (a) June 11-40 (b) H. H. Grier
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day Seventh
year 1940 hour 12:30 minute P M.

21. I hereby certify that I attended the deceased from Sec., 1939, to June 5, 1940
that I last saw her alive on June 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial degeneration 2 years

Due to Arterial Sclerosis ?

Due to 92C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

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

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? 938

(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature Dr. H. H. Focht (M. D. or other) MR
Address Strafford Mo. Date signed 6/11/40

RECEIVED

Greene County Health Office,

County File Number 40-7-49

Date Filed 7-10-40

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: [Signature]

License Embalmer No. 3316

P. O. Address Marshfield 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.