

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
STANDARD CERTIFICATE OF DEATH

State File No. **28108**

Registration District No. **89** Primary Registration District No. **5131** Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Bates**
 (b) City or town **Pope's Bluff Mo.**
 (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) **2**
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community **40 yrs**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **0** (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

3. (a) PRINT FULL NAME **Loxe Morgan b. 25**
8. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **29**
 year **1946** hour **15** minute **1** M.

4. Sex **M** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **Wid.**
6. (b) Name of husband or wife **Dick Morgan** **6. (c) Age of husband or wife if**
 alive _____ years
7. Birth date of deceased **Sept 9 1851**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **7-16-** 19**40** to **8-29** 19**46**
 and that I last saw her alive on **8-28-** 19**40**
 and that death occurred on the date and hour stated above.

8. AGE: Years **88** Months **11** Days **20**
 If less than one day _____ hr. _____ min.

Immediate cause of death
Chronic Myocarditis
Mitral Insufficiency
 Due to _____
 Due to _____

9. Birthplace **Kentucky** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

11. Industry or business _____
MOTHER FATHER
12. Name **Dick Pulley**
18. Birthplace **Ky** (City, town, or county) (State or foreign country)
14. Maiden name **V. Gally Raulitt**
15. Birthplace **Ky** (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant's own signature **Daisy Haring**
 (b) Address **Pope's Bluff Mo.**
17. (a) Burial (b) Date thereof **Aug 30 1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Burial**
18. (a) Signature of funeral director **Wm. D. Dunning**
 (b) Address **Pope's Bluff, Mo.**
19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

23. Signature **H. S. Searcy M.D.** (M. D. or other) _____
 Address **Pope's Bluff Mo.** Date signed **8/30/46**

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.....

Licensed Embalmer No.....

P. O. Address.....

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.