

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 2001

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

1. PLACE OF DEATH: **GREENE**
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1157 N. Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

8. (a) PRINT FULL NAME Elvis Morelock 642
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 15 1940
(Month) (Day) (Year)

8. AGE: Years 10 Months 7 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Springfield Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Inf

11. Industry or business _____
12. Name Ernest Morelock
13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Nellie Slavins
15. Birthplace Unknown Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Ernest Morelock
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Aug. 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) Aug. 25, 1940 (b) W.E. Handley M.D.
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1157 N. Park
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 23
year 1940 hour 4 minute 20 a.m.

21. I hereby certify that I attended the deceased from August 20 1940 to August 23 1940
that I last saw him alive on Aug 20 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bacteremia Duration about 1 week

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

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? Yes
While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature W. Roland Langston (M. D. or other) M.D.
Address Springfield Mo Date signed 8/24/40

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.

X