

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28676
Registrar's No. _____

Registration District No. 384 Primary Registration District No. 5535

1. PLACE OF DEATH:
(a) County Howell
(b) City or town (RURAL) Howell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
West Plains, Mo. Route 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No.
In this community 56 years.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME MARTHA JANE MORRISON
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Gid P. Morrison 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 20, 1852
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>9</u>	<u>15</u>	hr. _____ min.

9. Birthplace Kingston, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____
MOTHER FATHER { 12. Name James Edgemon
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Lillian Guffey
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Alice Chapin
(b) Address West Plains, Mo.

17. (a) Burial (b) Date thereof July 7, 1940
(Burial, cremation, or removal) Howell Valley Cem. (Month) (Day) (Year)
(c) Place: burial or cremation Howell Twp. Howell Co., Mo.

18. (a) Signature of funeral director Hal Lamburgh
(b) Address West Plains, Mo.

19. (a) 7-6-40 (b) Vida W. SIMONS
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howell
(c) City or town (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. West Plains, Rural Rt. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 5th
year 1940 hour 8: minute — A. M.

21. I hereby certify that I attended the deceased from January 1, 1938 to July 2, 1940
that I last saw her alive on July 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (Recurrent) Duration _____
Due to Arteriosclerosis and High blood pressure.
Due to _____

Other conditions (include pregnancy within 3 months of death) § 2 H

Major findings:
Of operations _____
Of autopsy _____

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? 3411

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature P. A. Sparks (M. D. or other) _____
Address West Plains, Mo. Date signed 7/9/40

WHILE 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.

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8401572

840829

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 Hal Thomburg.....

Licensed Embalmer No. 3408.....

P. O. Address West Plains, 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.