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10-39
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121492

FILED NOV. 12 1940

State File No.

Registration District No.

Primary Registration District No.

5720

Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Rural - Watson
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 75 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Rural
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME James Calvin Morrison

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Belle Morrison 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 28 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months I Days 14 If less than one day hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business a

12. Name Isaac Morrison

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant J. N. Morrison

(b) Address Westboro, Missouri

17. (a) Millsap Cemetery (b) Date thereof Oct. 13 40
(Place, cemetery, or funeral home) (Month) (Day) (Year)

(c) Place: burial or cremation Near Rockport

18. (a) Signature of funeral director Robert T. ...

(b) Address Westboro, Missouri

19. (a) Oct. 12 40 (b) J. N. Gray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1940 hour 3 A minute _____ M.

21. I hereby certify that I attended the deceased from Oct 5 - 40
_____ 19____ to Oct 12 1940
that I last saw him alive on Oct 11 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Organic Brain

Due to old age

Due to _____

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

Major findings: Of operations None

Of autopsy none

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 _____

23. Signature James A Gray (M. D. or other) _____

Address WATSON MO Date signed Oct 18 / 40

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

MOTHER FATHER

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..... *Edward T. Tucker*

Licensed Embalmer No. 2824

P. O. Address Westboro, Missouri

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.