

1-10-39
17-39
FEB

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43062

JAN 20 1941 477

Primary Registration District No. 200

Registrar's No. 80

1. PLACE OF DEATH:

(a) County. Lewis
(b) City or town. Williamstown
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether
In this community. 2 years, months or days)

3. (a) PRINT FULL NAME. James Marion Morrow
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex. Male 5. Color or race. White 6. (a) Single, widowed, married, divorced. Widowed
6. (b) Name of Marjane Morrow or wife. 6. (c) Age of husband or wife if and deceased
7. Birth date of deceased. July 2 1858 (Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 14 If less than one day hr. min.

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

10. Usual occupation. Farmer

11. Industry or business

MOTHER FATHER { 12. Name. Elias Morrow
13. Birthplace. Unknown (City, town, or county) (State or foreign country)
14. Maiden name. Charity Downing
15. Birthplace. Unknown (City, town, or county) (State or foreign country)

16. (a) Informant. John Ray Morrow

(b) Address. Williamstown Mo

17. (a) Burial (b) Date thereof Dec 16 1940 (Month) (Day) (Year)

(c) Place: burial or cremation. Midway Mo Cemetery

18. (a) Signature of funeral director. James F. Beck

(b) Address. La Belle Mo

19. (a) Dec 21 1940 (b) P. W. Jennings (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Lewis
(c) City or town. Williamstown Mo (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16 th year 1940 hour 1:20 minute 20 P. M.

21. I hereby certify that I attended the deceased from Oct 28 1940, to Dec 16 1940;

that I last saw him alive on Dec 16 1940;

and that death occurred on the date and hour stated above.

Immediate cause of death. Bangreen of right foot

Due to a Burn

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature. C. E. Todd (M. D. or other) 3

Address. Williamstown Mo Date signed Dec 21 1940

151
99

RECEIVED

District Health Officer No: 10

District File Number 1-41-192

Date Filed JAN 16 1941

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. 3721
working under my personal supervision.

Signed

Norman W. Roder

Licensed Embalmer No.

3721

P. O. Address

Lasalle, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43062

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 477

Primary Registration District No. 200

Registrar's No. _____

1. PLACE OF DEATH

(a) County Lewis
(b) City or town Reedsburg T.P.
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

James Marion Morrow

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced wed

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

82

5

14

hr. min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) _____

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of foot a Burn

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

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 about Mar. 1937

(c) Where did injury occur? Near Williamson & Lewis (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm at home while fighting field fire

While at work? yes (Specify type of place) (e) Means of injury from fire

23. Signature W. C. E. Todd (M.D. or other)

Address Williamstown Mo Date signed 2/20/49

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

SUPPLEMENTARY

S-43062