DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 23 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4596

Registration District No. 838 Primary Registration District No. 609818. Registrar's No.

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

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R. F. D. # 4 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. R. F. D. # 4 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Thomas Slaughter Morehead
3. (b) If veteran, name war World
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 1 (Day) 1881 (Year)
8. AGE: Years 53 Months 7 Days 6 If less than one day hr. min.
9. Birthplace Dixon (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Benjamin Morehead
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mindie Tapp
15. Birthplace Kentucky (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Ira Wicks
(b) Address Dexter, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-41 (Month) (Day) (Year)
(c) Place: burial or cremation Old Bethel
18. (a) Signature of funeral director Blankenship-Strickland
(b) Address Dexter, Missouri
19. (a) 1/11/1941 (Date received by local registrar) (b) Jennie Pulliam (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7 year 1941 hour 6 minute 30 A. M.
21. I hereby certify that I attended the deceased from Jan 2, 1941, to Jan 7, 1941, that I last saw him alive on Jan 4, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis	3 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

W. C. Brickman

Major findings:
Of operations None
Of autopsy None

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? None (Specify type of place)
While at work? — (e) Means of injury —
23. Signature W. C. Brickman (M. D. or other) D.
Address Dexter Mo Date signed Jan 10 41

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
4-25-41
P1/X27852

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

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4596

Registration District No. 838 Primary Registration District No. 6098B Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Stoddard

(b) ~~City or town~~ Liberty 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)

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) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Slaughter Morehead

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 S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 53 Months 7 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis	
Due to N.M.D.	
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
(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 W. (M. D. or other)
Address Date signed