S. No. 2
—11-13
7. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8423

REC'D MAR 25 1948

Registration District No. 65

Primary Registration District No. 6143

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Texas

(b) City or town: Tyrone (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 years, months or days)

In this community: 500 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Texas 107

(c) City or town: Tyrone Mo. (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? years. 0

8. (a) PRINT FULL NAME: Weed S Morgan

3. (b) If veteran, name war:

8. (c) Social Security No.: Old age Assistance

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Anna Morgan

6. (c) Age of husband or wife if alive: 61 years

7. Birth date of deceased: Sept (Month) 22 (Day) 1860 (Year)

8. AGE: Years 80 | Months 4 | Days 19 | If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name:

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

MOTHER 14. Maiden name:

MOTHER 15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant: L. D. Lay

(b) Address: Tyrone Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 12 1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Tyrone Mo.

18. (a) Signature of funeral director: Earl Ellis

(b) Address: Cabool Mo.

19. (a) Feb 13 1941 (Date received local registrar) (b) Mrs Lou McMillin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1941 hour minute 12 M.

21. I hereby certify that I attended the deceased from 1/29/41, 19..., to ..., 19...; that I last saw him alive on 1/29/41, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Senility	
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:

(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: Garrett Lay Jr. M.D. (M. D. or other)

Address: Cabool, Mo. Date signed 2/12/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 34360
Date Filed

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 Fairlord V. Elliott

Licensed Embalmer No. 2252

P. O. Address Cabool Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
1—2-21-40
1 X22659

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. 8423

Registration District No. 865

Primary Registration District No. 6143

Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Texas

(b) ~~City or town~~: Cass Twp.
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME: Reed S. Morgan

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: M

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 80 Months 4 Days 19 If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business: None

MOTHER FATHER

12. Name: Lewis Morgan

13. Birthplace: Owen Co. (City, town, or county) Kentucky (State or foreign country)

14. Maiden name: Unk

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) May 3, 1941 (Date received by local registrar) (b) Mrs Julia Ice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 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	
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

(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: Garrett Hogg Jr. (M. D. or other)

Address: Cabool Mo. Date signed