WRITE PLAINLY, WITH UNFADING INK--THIS IS 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.

FILED AUG 11 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24529
Do not use this space.

011 1 7

85

1. PLACE OF DEATH
(a) County BUCHANAN — Registration District No. 1001
(b) Township — Primary Registration District No. — Registered No.
(c) or City ST. JOSEPH — (d) Street No. ST. JOSEPH HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 16 Days (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mr. George A. Morgan
(a) Residence, No. St. [X] Troy-Kansas
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 0
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single 0
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apl 28-1855
7. AGE 86 YEARS — MONTHS 2 — DAYS 11 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Centerville Iowa

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

17. INFORMANT (ADDRESS) Lester Hathway Troy-Kansas

18. BURIAL, CREMATION, OR REMOVAL
PLACE Troy Kans DATE 7-9-41, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. L. Karr Troy Kans

20. FILED July 9, 1941 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-9, 1941

22. I HEREBY CERTIFY, That I attended deceased from June 24th, 1941, to July 9th, 1941
I last saw him alive on July 8th, 1941 Death is said to have occurred on the date stated above, at 2:15 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral hemorrhage	1 week?
83	
Other contributory causes of importance:	
osteosclerosis	
	10 years

Name of operation None Date of —
What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury —, 19—
Where did injury occur? —
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) John R. Forgrave M.D. M. D.
(Address) 731 Forest St. 7-9-41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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 with the above constitutes grounds for revocation of license.)

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