No. 2
-13-40
17-39
X23159

26827

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED [illegible] 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 104 Primary Registration District No. ~~5153~~ 5145 Registrar's No. 223

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Rural / Rounds Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4 Mi. S. W. Fulton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway 14 0

(c) City or town Rural Rounds Prairie 0
(If outside city or town limits, write "RURAL")

(d) Street No. 4 Mi. S. W. Fulton
(If rural, give location)

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

3. (a) PRINT FULL NAME MARGARET N. MORRIS

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced 2 Widowed

6. (b) Name of husband or wife E. M. Morris

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

7. Birth date of deceased Oct. (Month) 23 (Day) 1853 (Year)

8. AGE: Years 88 Months 8 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business At Home

MOTHER FATHER
12. Name David Henderson
13. Birthplace _____ (City, town, or county) Kentucky / (State or foreign country)

MOTHER FATHER
14. Maiden name Mary Blattenburg
15. Birthplace _____ (City, town, or county) Kentucky / (State or foreign country)

16. (a) Informant Mrs Omer A. Kemp
(b) Address Fulton, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/42 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Carmel.

18. (a) Signature of funeral director Geo. G. Wallace
(b) Address Fulton, Mo.

19. (a) 7-18-1942 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

1147

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17, year 1942 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from 3/29/41, 19__, to 7/13, 1942, that I last saw her alive on 7/13, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death chronic myocarditis	
Due to arteriosclerosis	several years
Due to	
Other conditions Hypostatic pneumonia (Include pregnancy within 3 months of death)	± 1 week

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 0

23. Signature Henry Wurst (M. D. or other) M.D.
Address Fulton, Mo. Date signed 7/18/42

(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 Elbert E. Wiles

Licensed Embalmer No. 4168

P. O. Address Fulton, 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, fact should be so stated above.

No. 2B
-8-21-41
X29288

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. 26827

Registration District No. 104 Primary Registration District No. 5165 Registrar's No.

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(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 Life

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 Margaret H. Morris
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife E M
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 23 (Day) 1853 (Year)

8. AGE: Years 88 Months 8 Days 23 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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 July day 7 year 1942 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.

	Duration
Immediate cause of death Chronic myocarditis	
Due to arterio sclerosis several yrs	
Due to	
Other conditions (Include pregnancy within 3 months of death) Hypostatic pneumonia (bilateral)	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY