S. No. 2
M—9-4-41
5-17-39
I X29484

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. 17886

FILED JUN 14 1943

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 44

1. PLACE OF DEATH:

(a) County: GREENE

(b) City or town: Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 Days (Specify whether years, months or days)
In this community Six Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No.: 903 South Newton
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: ----------

3. (a) PRINT FULL NAME: CLARENCE ~~[illegible]~~ Court MORRIS

3. (b) If veteran, name war: Unknown

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Julia Belle Morris

6. (c) Age of husband or wife if alive: 54 years

7. Birth date of deceased: February (Month) 23, (Day) 1890 (Year)

8. AGE: Years: 53 ✓ Months: 3 Days: 7 If less than one day: ---- hr. ---- min.

9. Birthplace: Law~~rence~~ County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Stockman and Farmer

11. Industry or business: Used Car Dealer

FATHER
12. Name: Mr. Thomas Morris
13. Birthplace: Unknown (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Allie Bell Sageser
15. Birthplace: Law~~rence~~ County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Morris
(b) Address: 903 South Newton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Cave Springs Cemetery

18. (a) Signature of funeral director: Fred C. Thieme
(b) Address: 1100 Boonville St. City

19. (a) 6-1-43 (Date received local registrar) (b) for W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day Thirthy year 1943 hour One minute 45 P. M.

21. I hereby certify that I attended the deceased from May 19th 1943, 19..., to May 30th 1943, 19..., that I last saw h. alive on May 30 - 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Suppurative Hepatitis	3 weeks
Due to: Suppurative Diverticulitis	3-4 weeks
Due to: Diverticulitis coli - Congenital	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: Mass in Recto-Sigmoid

Of autopsy: Abscess of Diverticuli & Suppurative Hepatitis

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: Howard Bloom (M. D.)
Address: Springfield Mo. Date signed 5/30/43

(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.....Fred C. Thieme.....

Licensed Embalmer No.....2899.....

P. O. Address.....Springfield, Missouri

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, fact should be so stated above.