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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39343

FILED DEC 9 1943  
Registration District No. 351

State File No. \_\_\_\_\_  
Registrar's No. 18

Primary Registration District No. 6189

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

1. PLACE OF DEATH:

(a) County Taney

(b) City or town Rural - Swan 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)

In this community \_\_\_\_\_ (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Taney

(c) City or town Rural - Swan Twp.  
(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 MANDA ELIZABETH MORGAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27<sup>th</sup>  
year 1943 hour 4 minute 15 P.M.

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife TOM MORGAN 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased APRIL 4 1859  
(Month) (Day) (Year)

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.

Immediate cause of death No Medical Attention Duration

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name John A. Bryant

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

14. Maiden name Pata PIERSON

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

16. (a) Informant JERRY S. MORGAN

(b) Address Taneyville Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Sept 28 - 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brown Cem.

(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? \_\_\_\_\_

18. (a) Signature of funeral director Mrs. Home Farm Home

(b) Address Mrs. Home, Arkansas

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

19. (a) Sept 28 - 43 (b) Jeannette Davis  
(Date received local registrar) (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED  
District Health Officer No. 6,  
District File Number 243-1343  
Date Filed DEC 8 1943

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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 18

Registration District No. 351

Primary Registration District No. 6189

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

1. PLACE OF DEATH:

(a) County Janey  
(b) City or town Princeton Swan Inf  
(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 (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Manda E. Morgan  
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 6. (c) Age of husband or wife if alive.

7. Birth date of deceased. April 4  
(Month) (Day) (Year)

8. AGE: Years 84 Months Days If less than one day.

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

10. Usual occupation

11. Industry or business

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 27  
year, 1943 day, minute. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death. no. Medical attention Duration

Due to Probable cause of  
Due to leukaemia - Senility  
Other conditions (include pregnancy within 3 months of death)

Major findings:  
Of operations. 1622  
Of autopsy. 1622  
PHYSICIAN

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?

While at work? (Specify type of place) Means of injury. Register  
23. Signature George Foreyth (M.D. or other)  
Address Foreyth, Mo Date signed 7/18/43

SUPPLEMENTARY

S-39342