

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1944
Registration District No. 275
1042

Primary Registration District No. 3053

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Phelps Co

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

(c) Name of hospital or institution:
McFarland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution six (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Benjamin Franklin Morton

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Verna Morton 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Nov 19 1899
(Month) (Day) (Year)

8. AGE: Years 49-50 Months - Days 15 If less than one day
hr. min.

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

10. Usual occupation Auto Mechanic

11. Industry or business X

MOTHER FATHER { 12. Name Alex Morton

13. Birthplace Phelps Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Ida Baird

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

16. (a) Informant Ruth Morton

(b) Address Salem Mo

17. (a) burial (b) Date thereof 12/6/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove Cem

18. (a) Signature of funeral director [Signature]

(b) Address Salem Mo

19. (a) 12-5, 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4
year 1943 hour 11:00 PM minute M.

21. I hereby certify that I attended the deceased from Nov 28
1943 to Dec 4 1943

that I last saw him alive on 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Alcoholism

Due to Hobnail Lacer

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (e) Means of injury

23. Signature [Signature] (M. D. or other)

Address [Address] Date signed 12/9/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Carl H. Spence*.....
.....
Licensed Embalmer No. *9320*
P. O. Address..... *Salmon, Mo.*.....

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. gan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McFarland Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Benjamin F. Norton

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 Nov 19 1913
(Month) (Day) (Year)

8. AGE: Years 50 Months _____ Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-4-1943 (b) J. H. Hatter
(Date received local registrar) (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 Dec Day 4 Year 1943 Hour _____ 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 _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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) (e) Means of injury _____

Signature _____ (M. D. or other) _____
Address _____ Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-43359