

FILED FEB 9 1944

Registration District No. **72** Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community 56 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 614 North 5th St.
(If rural, give location)

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

3. (a) PRINT FULL NAME John Quinton Morrow

3. (b) If veteran, name war No

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 Fannie A. Morrow

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased February 22 1859
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>10</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Retired Grocerman

11. Industry or business _____

MOTHER FATHER {

12. Name George Morrow

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

14. Maiden name Unknown

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

16. (a) Informant Jamie A. Morrow

(b) Address 614 No. 5th. St. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/1944
(Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Shelley Meierhoffer

(b) Address 1302 Faraon St. St. Joseph, Missouri

19. (a) 1-18-44 (Date received local registrar)

(b) Rae Heigoy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 15th.
year 1944 hour 2:38 minute A. M.

21. I hereby certify that I attended the deceased from January 13th
1944 to January 15th, 1944
that I last saw him alive on January 14th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, spreading, both lungs unknown
Duration _____

Due to _____

Due to _____

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

PHYSICIAN _____

Major findings: _____
Of operations: _____
Of autopsy: _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Reigen _____
Social Welfare Board (M. D. approval) 1/17/44
Address St. Joseph, Mo Date signed 1-17-44

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 *Albert P. Harrington*.....

Licensed Embalmer No. 3258 Missouri

P. O. Address. St. Joseph, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 80

1. PLACE OF DEATH: Buchanan
 (a) County Buchanan
 (b) City or town St Joseph
 (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

3. (a) PRINT FULL NAME John O. Ironson
 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 Feb. 22 1957
 (Month) (Day) (Year)

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

9. Birthplace _____ (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) _____ (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) _____ (b) _____
 (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 Jan day 13 year 1944 hour 8: minute 38 A.M.
 21. I hereby certify that I attended the deceased from January 13, 1944 to January 15, 1944
 that I last saw him alive on January 14, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Aspirating pneumonia
acute bronchitis lobes
 Duration 3 days

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

Major findings: 108
 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 Regina Smith M.D.
 Address Social Welfare Board (M. D. or other) _____
 Date signed 2/14/44

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

SUPPLEMENTAL

FEB 1944

2150