

FILED MAY 15 1944

Registration District No. 211

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Moberly  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wabash Hospital  
(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

3. (a) PRINT FULL NAME Jesse Daniel Morgan

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased April 27<sup>th</sup> 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 11 26 hr. min.

9. Birthplace neb 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Engineer

11. Industry or business Wabash R.R.

12. Name Daniel Morgan

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

14. Maiden name Elizabeth Chapman  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Alice Doyle

(b) Address RFD Moberly, Mo

17. (a) Removal (b) Date thereof Apr. 26 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Des Moines, Ia

18. (a) Signature of funeral director Mahon and Son

(b) Address Moberly Mo

19. (a) 4-25-44 (b) Jenna Kave  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
(c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
(d) Street No. RFD Highway U.S. 74  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23<sup>rd</sup>  
year 1944 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from April 3  
1944 to April 23 1944  
that I last saw him alive on April 23 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure  
Duration \_\_\_\_\_

Due to arteriosclerosis [cerebral]

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

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

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) no  
(b) Date of occurrence no  
(c) Where did injury occur? no  
(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 Eric Handley (M. D. or other) \_\_\_\_\_  
Address Wabash Hospital Moberly Mo Date signed 4-25-44

NOV 8 1949

RECEIVED

District Health Officer No. 10

District File Number S-44-1012

Date Filed MAY 12 1944

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 Frank D. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. May  
Registrar's No. V102

Registration District No. 279 Primary Registration District No. 2056

1. PLACE OF DEATH

(a) County Randolph  
(b) City or town Maechly  
(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 years, months or days)

3. (a) PRINT FULL NAME

Jesse O. Morgan

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 W

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

7. Birth date of deceased April 27 1873  
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 15 If less than one day \_\_\_\_\_ min.

9. Birthplace neb  
(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) \_\_\_\_\_ (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 April 23  
year 1944 hour \_\_\_\_\_ minute 37 M.

21. I hereby certify that I attended the deceased from April 23 1944; that I last saw him alive on April 23 1944; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Heart failure  
chronic myocarditis 2 years

Due to arteriosclerosis (cerebral)

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) \_\_\_\_\_ no

(b) Date of occurrence \_\_\_\_\_ no

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) no

(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 Eric Handley (M. D. or other) \_\_\_\_\_

Address Wabash Hospital, Maechly Mo Date signed 5-16-44

SUPPLEMENTAL

MOTHER, FATHER

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

15585

1921

1921