DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 20 1944

Registration District No. 27

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25288

Primary Registration District No. 0829

Registrar's No. 23

1. PLACE OF DEATH:

(a) County: New Madrid

(b) City or town: Rural Portageville
(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: 1 (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: New Madrid

(c) City or town: 72
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location)

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

3. (a) PRINT FULL NAME: James Lee Morris

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M 2

5. Color or race: Negro

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: June (Month) 27 (Day) 1943 (Year)

8. AGE: Years 1 | Months | Days | If less than one day: hr. min.

9. Birthplace: New Madrid Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business: None

FATHER
12. Name: Frank Morris
13. Birthplace: Miss 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Hattie McClure
15. Birthplace: Miss 1
(City, town, or county) (State or foreign country)

16. (a) Informant: L. L. Morris
(b) Address: Portageville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-28-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Portageville Mo

18. (a) Signature of funeral director: Noel C. Dean
(b) Address: Portageville Mo

19. (a) (Date received by local registrar) (b) Ellen DeLisle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1944 hour 10 minute 40 A.M.

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

	Duration
Immediate cause of death	
Due to	
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):
(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: (M. D. or other)
Address: Date signed:

1369 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 744-94
Date Filed 7-7-94

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 compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr Killian

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 241 Primary Registration District No. 5829 Registrar's No. 23

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural Portage 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 years, months or days)

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

3. (a) PRINT FULL NAME James Lee Morris

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 21 (Day) 1943 (Year)

8. AGE: Years 1 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 27
year 1944 hour minute M.

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

	Duration
Immediate cause of death Bronchopneumonia	2 da
Due to Dysentery	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

21C

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 John J Killian (M. D. or other)
Address Date signed

25288