

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35547  
Registrar's No. 174

FILED NOV 8 1944  
Registration District No. 300

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Nevada Washington Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp No 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
in this community 13 years 2 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town St Louis 109  
(If outside city or town limits, write "RURAL")  
(d) Street No. City Sanitarium  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MABLE-MORGAN

3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex female 5. Color or race wh.  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife James Morgan 6. (c) Age of husband or wife if alive unknown years  
7. Birth date of deceased Sept 1 1876  
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 22  
If less than one day hr. min.

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

10. Usual occupation f. cook and chambermaid

11. Industry or business none

12. Name unknown

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 Records State Hosp

(b) Address Nevada Mo.

17. (a) Burial (b) Date thereof 10 25 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Nevada Mo.

(b) Address 10-24-A

19. (a) 10-24-A (b) Doyle B. Keurck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23  
year 1944 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 1939 to Oct 23 1944  
that I last saw her alive on Oct 23 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Head of Pancreas

Due to with metastasis to liver and gall bladder

Other conditions Dementia Precox  
(Include pregnancy within 3 months of death)

Major findings: Of operations no operation

Of autopsy yes - findings as above

22. If death was due to external causes, fill in the following: No

(c) 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? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Paul L. Barone (M. D. or other)

Address State Hosp No 3 Date signed Oct 24/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File No. 10-44-1258

Date Filed 11-7-44

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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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed L. B. Feun

Licensed Embalmer No. 1760

P. O. Address Neosho 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.**