

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3254

FILED JAN 19 1945

Registration District No. 3059

Registrar's No. 277

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

1. PLACE OF DEATH:

(a) County St. Francois

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

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

(d) Length of stay: In hospital or institution 22 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Helena Morrison

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

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

6. (b) Name of husband or wife M. J. Morrison 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased April 25 1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 8 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business None

MOTHER FATHER

12. Name Theodore Goeschel

13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Carroll Funeral Home
(b) Address itchfield, Ill.

17. (a) Holy Cross (b) Date thereof Jan. 6 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holy itchfield, Ill.

18. (a) Signature of funeral director W. J. Bessler 527
(b) Address 819 E. Union Ave. itchfield, Ill.

19. (a) 1-8-45 (b) J. J. J. J. J.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Francois

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3rd
year 1945 hour 2 minute 50 P. M.

21. I hereby certify that I attended the deceased from Dec 10th, 1944 to Jan 3, 1945
that I last saw her alive on Jan 3rd, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Duration 3 hours

Due to Coronary Disease + Myocarditis 14x.

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 73

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? _____

While at work _____ (Specify type of place) (c) Means of injury 0

23. Signature Geo. L. Watkins (M. D. or other)
Address Forresterington Mo Date signed 1-7-45

MAR 19 1947

STATE OF MISSISSIPPI
District Health Officer No. 4
District File Number 145-126
Date Filed 1-16-45

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 comply with the above constitutes grounds for revocation of license.)

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

No Embalming
W. H. Williams