

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5789

State File No. _____

Registration District No. 26

Primary Registration District No. 2203

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Miami Station, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Thomas Henry Morris

3. (b) If veteran, name war #
3. (c) Social Security No. 492-18-5028

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 17 1889
(Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 21
If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business Worked for Saline Co. Asphalt Co.

12. Name T.A. Morris

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

14. Maiden name Ida Morris

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

16. (a) Informant Elliot Morris-Son

(b) Address Blackwater, Mo.

17. (a) Buried (b) Date thereof 2/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arrowrock Cemetery

18. (a) Signature of funeral director J. Leslie Sussman

(b) Address Marshall

19. (a) 2-10-1945 (b) Arthur Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 209 E. Eastwood
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 8th
year 1945 hour 1 minute P M.

21. I hereby certify that I attended the deceased from _____
Coroner Call, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death broken neck,

Due to collision between truck and Wabash Train, Engine Nos. 691 and 687
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) Accident
(b) Date of occurrence February 8, 1945 12:30 P.M.
(c) Where did injury occur? Miami Station, Carroll Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Railroad crossing

While at work? yes (Specify type of place) collision with train
(e) Means of injury Coroner

23. Signature Charlie Ruth (M.D. or other)
Address Tina, Mo. Date signed 2-8-45

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

RECEIVED
RECEIVED

District Health Officer No. 8.

District File Number

Date Filed

3/13/45

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.....

J. Leslie Sweeney

Licensed Embalmer No.

3235

P. O. Address

Marshall, 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.