

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1945
Registration District No. 212

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17549
Registar's No. 0372378

Primary Registration District No. 4326

1. PLACE OF DEATH
(a) County MILLER
(b) City or town Olson *Satine*
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miller
(c) City or town Olson
(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 EARNET W. MORRIS
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April ~~22~~ 22 day 1945 hour 11 minute 10 P. M.
21. I hereby certify that I attended the deceased from 1 1945 to Apr 22 1945
that I last saw h. / w. alive on Apr 15 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN 8 1870
(Month) (Day) (Year)

Immediate cause of death Cancer of left kidney & metastatic cancer of lungs Duration 1 yr.
Due to _____
Due to _____

8. AGE: Years 75 Months 3 Days 14 If less than one day hr. min.

Other conditions diabetes mellitus
(Include pregnancy within 3 months of death)

9. Birthplace High Point Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Banker

MOTHER FATHER
11. Industry or business _____
12. Name B. H. Morris
13. Birthplace Lathrop Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Bruce
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy low
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Helen Simpson
(b) Address ENON Mo.
17. (a) Burial (b) Date thereof 4-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation OLEAN CEM

22. If death was due to external causes, fill in the following:
(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? _____

18. (a) Signature of funeral director W. L. Preece
(b) Address Preece Mo
19. (a) 4/24/45 (b) W. D. Spearman
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature W. L. Preece (M. D. or other) _____
Address Elton Mo Date signed 4/23/45

1114

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Miller County Health Dep't.

County File Number 45-36

Date Filed 5-5-45

RECEIVED

[Faint, illegible handwritten notes and scribbles]

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 *[Handwritten Signature]*
Licensed Embalmer No 23071
P. O. Address *[Handwritten 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 22

Registration District No. 212 Primary Registration District No. 4226

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Osceola
(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 Earnest W. Morris

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

4. Sex M 5. Color or race W 6. (a) Single, 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 Jan (Month) 1 (Day) 1945 (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Mo (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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) M. Searcy (Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER, FATHER

17549