

FILED SEP 7 1945

Registration District No. 277

Primary Registration District No. 5786

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

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston (rural)
(c) Name of hospital or institution: R#1
(d) Length of stay: In hospital or institution 4 Years
In this community 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miss.
(c) City or town Charleston
(d) Street No. 214 S. Locust
(e) Citizen of foreign country? No
If yes, name country None

3. (a) PRINT FULL NAME Murry Morgan
(b) If veteran, name war -----
(c) Social Security No. 498-24-028

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 27 th
year 1945 hour 5 minute 30 P.M.

4. Sex M 5. Color or race Negro
6. (a) Single, widowed, married, divorced N.K.
7. Birth date of deceased Not Known 1895 years

21. I hereby certify that I attended the deceased from
Attended by Coroner
that I last saw him alive on ----- 19-----
and that death occurred on the date and hour stated above.

8. AGE: Years 50 Months ----- Days -----
If less than one day ----- hr. ----- min.

Immediate cause of death Acute Alcoholism
Due to -----
Due to -----

9. Birthplace N.K.
10. Usual occupation Day Laborer

Other conditions -----
(Include pregnancy within 3 months of death)
Major findings:
Of operations -----
Of autopsy -----

11. Industry or business -----
12. Name N.K.
13. Birthplace N.K.
14. Maiden name N.K.
15. Birthplace N.K.

PHYSICIAN -----
Underline the cause to which death should be charged statistically.

16. (a) Informant Richard Carr
(b) Address Charleston ? Mo.
17. (a) Burial (b) Date thereof 8-28-45
(c) Place: burial or cremation Oak Grove, Charleston

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? -----
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mo.

18. (a) Signature of funeral director John F. Zimmerman
(b) Address Charleston, Mo.
19. (a) 9/1/45 (b) John F. Zimmerman
(Date received local registrar) (Registrar's signature)

(Specify type of place) -----
While at work? ----- (e) Means of injury -----
23. Signature John F. Zimmerman M.D. or other -----
Address Charleston Mo. Date signed 5/28/45

RECEIVED

District Health Office No. 2,

District File Number 945-2977

Date Filed 9-5-75

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.

Not Embalmed