

FILED NOV 28 1945

Registration District No. **217**

Primary Registration District No. **4328**

Registrar's No. **81**

1. PLACE OF DEATH:

(a) County **Miss. ss. pp?**
(b) City or town **Beetland**
(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 **2 weeks**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ill.** (b) County **M. Johnson**
(c) City or town **Vienna**
(If outside city or town limits, write "RURAL")
(d) Street No. **11**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **WILLIAM H. MORGAN**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **NONE**

4. Sex **M** 5. Color or race **wt** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MARY A. MORGAN** 6. (c) Age of husband or wife if alive **DEAD** years
7. Birth date of deceased **MAY 15 - 1863**
(Month) (Day) (Year)

8. AGE: Years **82** Months **5** Days **16** If less than one day hr. min.

9. Birthplace **Pope County, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ben Morgan**

(b) Address **Dongola, Ill.**

17. (a) **Burial** (b) Date thereof **Nov 2-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dongola Cemetery**

18. (a) Signature of General Director **Calmer**

(b) Address **Dongola, Ill.**

19. (a) **11/1/45** (b) **Mrs. John Bondurant**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **1**
year **45** hour **7** minute **A.M.**

21. I hereby certify that I attended the deceased from **27th Oct.**
19 **45**, to **31 Oct.** 19 **45**;
that I last saw him alive on **Oct. 31** 19 **45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **6 days**
Due to **old a. c.**

Other conditions: **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**
Of autopsy **None**
PHYSICIAN **None**
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? _____

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

23. Signature **C. C. Presnell** (M. D. or other) _____
Address **Charles St. No.** Date signed **11/1/45**

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

700

RECEIVED

District Health Office No. 2,

District File Number 1145-32

Date Filed 1-8-45

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 _____

working under my personal supervision.

Registered Apprentice No. 970

Signed _____

Licensed Embalmer No. 4540

P. O. Address Douglass

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.