

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2739**
Registrar's No. **98**

FILED FEB 28 1946

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1501 West Olive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Lifelong**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **39**
(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL")
(d) Street No. **1501 West Olive** **6**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **William David Elijah Morrison**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **XX** years
7. Birth date of deceased **August 18 th. 1866**
(Month) (Day) (Year)

8. AGE: Years **79** Months **5** Days **13** If less than one day hr. min.

9. Birthplace **UNK.** **Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

MOTHER FATHER { 12. Name **John Lawrence Morrison**
13. Birthplace **UNK.** **Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Jane Shropshire**
15. Birthplace **UNK.** **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **John T. Morrison**
(b) Address **1501 West Olive, SPED., MO.**

17. (a) **Burial** (b) Date thereof **2-3, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **W.L. Dunn**

(b) Address **Springfield, Mo.**

19. (a) **2-2-46** (b) **W. H. Handley**
(Date received local facilities) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **31** st. year **1946** hour **4** minute **15** P. M.

21. I hereby certify that I attended the deceased from **Jan 26** 19**46** to **Jan 31** 19**46**
that I last saw him alive on **Jan 30** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Duration **5 days**

Due to _____

Due to **UNK.**

Other conditions **UNK.**
(Include pregnancy within 3 months of death)

Major findings: Of operations **UNK.** Of autopsy **UNK.**

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) **UNK.**
(b) Date of occurrence **UNK.**
(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? **UNK.** (Specify type of place) Means of injury _____

23. Signature **Robert Williams** (M. D. or other) **UNK.**
Address **Springfield Mo** Date signed **2-1-46**

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.W. Maples*
Licensed Embalmer No..... *2985*
P. O. Address..... *Clear 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.

X