

FILED APR 15 1946

Registration District No. 143

Primary Registration District No. 4232

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town Willow Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Home
(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

EMMA MORGAN

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

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Jesse M. 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Nov. 5 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>62</u>		<u>4</u>	<u>10</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business Housewife

12. Name John Schmel

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

14. Maiden name Rosa Kuhn

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

16. (a) Informant Jesse M. Morgan

(b) Address Willow Springs

17. (a) BURIAL (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pine Grove Cem.

18. (a) Signature of funeral director R. W. Barber

(b) Address 127 Pine Grove

19. (a) 3-16-46 (b) St. M. Miller
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
 (c) City or town P. URAI
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15
 year 1946 hour 4 am minute _____ G.M.

21. I hereby certify that I attended the deceased from March 12
1946 to March 15 1946
 that I last saw her alive on March 14 1946
 and that death occurred on the date and hour stated above

Immediate cause of death Anginal Pectoris Duration _____

Due to arterial condition

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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) (e) Means of injury

23. Signature G. B. Arest (M. D. or other) _____

Address Willow Spring Date signed 3/18/46

MOTHER FATHER

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

RECEIVED

District Embalmer Officer No. 5,

District No. 446276

Date Filed 4-13-46

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 R. W. Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Grove, Pa.

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. April
Registrar's No. 14

Registration District No. 143

Primary Registration District No. 4232

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town William Springs
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Emma Morgan

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced in

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Nov. 5
(Month) (Day) (Year)

8. AGE: Years 62 Months 4 Days 7 (if less than one day) _____ hr. _____ min.

9. Birthplace Frederick, Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business house-keeping

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1946 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) (e) Means of injury _____

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

Address _____ Date signed _____

Supplemental

9229