

No. 2
M-5-43
v. 5-17-39
I X36671

FILED SEP 5 1946
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Registration District No. 5463A
Primary Registration District No. 5463A

Registrar's No. 20

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

1. PLACE OF DEATH: GREENS

(a) County: GREENS

(b) City or town: Rural Jackson Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ~~Springfield~~ R.F.D. # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 11 Years (Specify whether years, months or days)

In this community 11 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greens 39

(c) City or town: Rural 0
Stratford (If outside city or town limits, write "RURAL")

(d) Street No.: ~~Springfield~~ R.F.D. 1 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country: _____

3. (a) PRINT FULL NAME: BESSIE MAY MORRISON

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3rd year 1946 hour 3:15 P.M. minute M.

4. Sex: Female / 5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: James W. Morrison

6. (c) Age of husband or wife if alive: 76 years

7. Birth date of deceased: May 23, 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1, 1946 to Aug 3, 1946 that I last saw her alive on Aug 3, 1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

66 2 10 hr. min.

Immediate cause of death: Tuberculosis of Lungs 7 years
Duration: 7 years

Due to: _____

Due to: _____

9. Birthplace: Parsons, Kansas /
(City, town, or county) (State or foreign country)

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

10. Usual occupation: House wife

11. Industry or business: Home

Major findings: Of operations: 13/10
Of autopsy: _____

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

MOTHER FATHER { 12. Name: George Mattox

13. Birthplace: Unknown, Virginia /
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown, Unknown /
(City, town, or county) (State or foreign country)

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

16. (a) Informant: Mr. James W. Morrison

(b) Address: ~~Springfield~~, MO. R.F.D. # 1

17. (a) Burial (b) Date thereof: August 6, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Danforth Cemetery

(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? _____

18. (a) Signature of funeral director: Fred C. Thieme

(b) Address: Springfield, MO.

19. (a) Aug-16-46 (b) Harry C. Giers
(Date received local registrar) (Registrar's signature)

* While at work? _____ (Specify type of place)

(c) Means of injury: _____

23. Signature: J.S. Britton (M. D. or other) M.D.
Address: Springfield Mo Date signed: _____

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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.....

Ralph Thiene

Licensed Embalmer No. 3681

P. O. Address. Springfield, 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.