

No. 2
-7-43
-17-39
X35897

FILED OCT 11 1946

State File No. _____

Registration District No. 96

Primary Registration District No. 3350

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural - Lincoln
(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 _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas
(c) City or town Rural - Lincoln
(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 _____

3. (a) PRINT FULL NAME

Lydie L. Morrow

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry R. Morrow

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

7. Birth date of deceased Dec 4 1977
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 8
If less than one day hr. _____ min. _____

9. Birthplace Lynn County, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Richard M. Davis

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

14. Maiden name Mother A. Stevens

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

16. (a) Informant Mr. Frank Morrow

(b) Address Urbana, Mo

17. (a) Burial (b) Date thereof Sept-13-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howard Chapel Cem.

18. (a) Signature of funeral director Vaughan-Ries

(b) Address Urbana, Mo.

19. (a) 9-30-46 (b) Ernest Jackson
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1946 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from June-15 to Sept 12
that I last saw her alive on Sept 11
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke vascular thrombosis
Duration 1 hr

Due to _____

Due to Coronary Artery 2 mo

Other conditions (Include pregnancy within 3 months of death) 124

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 Dr. A. Jones (M. D. or other) MD

Address Urbana, Mo Date signed Sept 12, 1946

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

46

REC

D:

Officer No. 7,

9-46-1032

Date issued

10-9-46

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 Allen W. Vaughan

Licensed Embalmer No. 21156

P. O. Address Allen W. Vaughan

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.

Registration District No. 96

Primary Registration District No. 5350

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Lydell J. Morrow

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

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

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

7. Birth date of deceased Dec 4
(Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days _____ (if less than one day) _____
hr. _____ min. _____

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

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

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 Mr. Frank Morrow

(b) Address Urban, Mo

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-30-46 (b) Grace Petric
(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 _____ 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)

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY 2

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

29907