

FILED OCT 14 1946

Registration District No. 324

Primary Registration District No. 3072

State File No.

Registrar's No. 167

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbon Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
In this community 50 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline 97
(c) City or town R.F.D. No. 1
(If outside city or town limits, write "RURAL") 5
(d) Street No. Miami, Mo.
(If rural, give location) 5
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nettie Frances Morton

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Chas. Morton 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased July 3rd 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 27 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

FATHER { 12. Name J. H. James
13. Birthplace Mo.
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Addie Doane
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Rufus James
(b) Address R.F.D. # 1, Miami, Mo.

17. (a) Burial (b) Date thereof 9-30-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Hill Brothers Slater, Mo.
(b) Address _____

19. (a) 9-30-46 (b) mas J. O. Wentworth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th
year 1946 hour 7 minute P M.

21. I hereby certify that I attended the deceased from January 2, 1946 to Sept. 27, 1946
that I last saw her alive on Sept. 27, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal Obstruction 48 hrs.
peritonitis

Due to Cholecystectomy & marked adhesions of small intestine 2 hrs.
Due to Empyema of Gall Bladder 9 mo.
Ch. Hepatitis

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

Major findings: Chy. cholecystitis 126
Of operations Cholelithiasis
Ch. Hepatitis

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 _____

Signature A. G. McSweeney (M.D. or other) _____
Address Slater, Mo. Date signed 9/28/46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 10-12-46

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.....

A. C. Hill

Licensed Embalmer No.....

P. O. Address.....

*3090
State-7*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. *324*

Primary Registration District No. *3072*

Registrar's No. *167*

1. PLACE OF DEATH:
(a) County *Saline*
(b) City or town *Marshall*
(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

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 _____

3. (a) PRINT FULL NAME *Nellie F. Merton*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month _____ Year *1946* Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him/her _____ above on _____ and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year) _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years *60* Months *2* Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country) *Iowa*

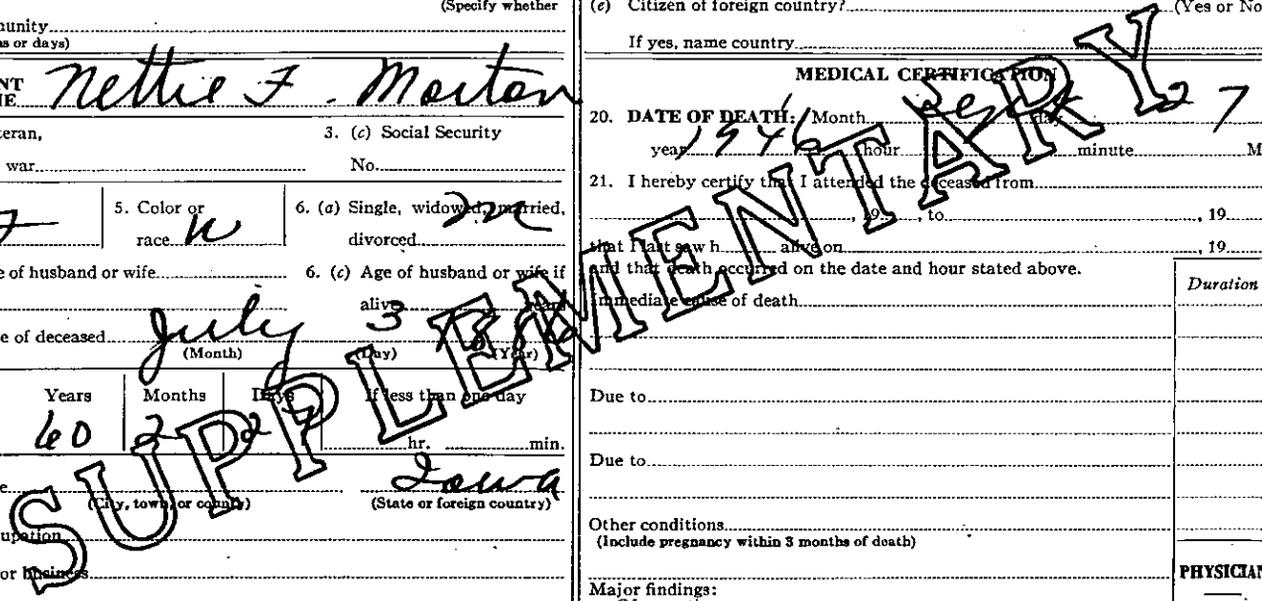
Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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)

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) _____ (c) Means of injury _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____

19. (a) *9-30-46* (b) *Mrs. T. Westbrock* (c) _____
(Date received local registrar) (Registrar's signature) _____
Signature _____ (M. D. or other) _____
Address _____ Date signed _____



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

380

32395