

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39809

FILED JAN 13 1946

Primary Registration District No. 3008

Registrar's No. 424

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hospital No. 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 3 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ¹⁴

(c) City or town Jackson ¹
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) ²

(e) Citizen of foreign country? _____ (Yes or No) ⁰

If yes, name country _____

3. (a) PRINT FULL NAME JAMES MORTON

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

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased Mar 16 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>9</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name DK

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

14. Maiden name DK

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

16. (a) Informant Records of State Hospital

(b) Address _____

17. (a) Removal (b) Date thereof Dec 24 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo.

18. (a) Signature of funeral director Charles Springer

(b) Address Springfield, Mo.

19. (a) 12 (b) Joan Moushiff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21
year 46 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from Dec 13, 1946, to Dec 21, 1946;
that I last saw him alive on 21 Dec, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia ^{Duration 5 days}

Due to _____

Due to _____

Other conditions marked general atrophic changes and emphysema
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy 10

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 0

23. Signature P. S. Tate (M. D. or other) _____
Address State Hospital No. 1 Date signed 21 Dec 1946

14
1
2
38623
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number
JAN 8 1947
Date Filed

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, ^{and} by _____

Kemer Farayth, Registered Apprentice No. 421
working under my personal supervision.

Signed Minnie L. Whelchel

Licensed Embalmer No. 2277

P. O. Address Brookline 201

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.