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5-43  
5-1739  
I X 36571

FILED MAY 21 1947

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 146

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

1. PLACE OF DEATH:

(a) County 2090  
(b) City or town Columbia Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
University Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 Days (Specify whether  
In this community Life (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 2090  
(c) City or town 7  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Baby Girl Morelock

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

4. Sex F / 5. Color or race W.

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

7. Birth date of deceased: 4 / 24 / 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1/2 hr. 40 min.

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

10. Usual occupation Premature Infant

11. Industry or business \_\_\_\_\_

12. Name James Crutchfield Morelock

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

14. Maiden name Eugenia Scott Browne

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

16. (a) Informant Mrs. Eugenia Morelock  
(b) Address East Ash Columbia Mo

17. (a) Unknown (b) Date thereof Unknown  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Spec. to Univ.

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 5-15-47 (b) Mrs. R.E. Palmer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25  
year 1947 hour 11:50 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 25 April  
\_\_\_\_\_ 1947 \_\_\_\_\_ 1947  
that I last saw him alive on 25 April \_\_\_\_\_ 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cordial  
Failure due to (24 weeks)  
Prematurity  
Due to Congenital atelectasis

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations 159  
Of autopsy \_\_\_\_\_

Duration

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address 205 Exchange Bldg Date signed 25 June 1947

Date filed 5-22-67

District File Number \_\_\_\_\_

District Health Officer No. 9

RECEIVED

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 38Primary Registration District No. 3006Registrar's No. 146

## 1. PLACE OF DEATH:

(a) County Boone  
 (b) City or town Columbia  
 (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

Infant Morelock

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 S

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

7. Birth date of deceased April 24 1947  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day \_\_\_\_\_ min. \_\_\_\_\_)

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

## 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 \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone  
 (c) City or town Columbia  
 (If outside city or town limits, write "RURAL")

(d) Street No. 1110 East Oak  
 (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Month April 1947 year \_\_\_\_\_  
 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her 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 [Signature] (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

5 1947

16496