

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44093

FILED JAN 6 1948

Registration District No. 27

Primary Registration District No. 6274

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Worth-rural-Middlefork township
(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 Life
years, months or days)

3. (a) PRINT FULL NAME Cathrene Ellen Morgan

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased December 8 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 0 5 hr. min.

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

10. Usual occupation housekeeper

11. Industry or business

12. Name Joseph Morgan
13. Birthplace Green Co. Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Kate Loraine Trump

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

16. (a) Informant Mrs. Josephine Smith

(b) Address Worth, Mo.

17. (a) burial (b) Date thereof 12-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wherton Cemetery

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Grant, City, Mo.

19. (a) December 22 (b) Leta E. Dawes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth

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

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13
year 1947 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from June 8
1947 to Dec 13 1947
that I last saw her alive on Dec 12 1947
and that death occurred on the date and hour stated above.

Immediate cause of death

Hypochondriac
followed with
Due to True melancholia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify) no

(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 B. J. Ross (M. D. or other)

Address Grant City, Mo. Date signed Dec 13, 47

(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Arch C. Dunfee

Licensed Embalmer No. 22652

P. O. Address St. Louis City Mo.

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

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