

FILED JUN 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16327

BIRTH NO.		REG. DIST. NO. 156	PRIMARY REG. DIST. NO. 2001	Registrar's No. 251
1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper 1949		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin		c. LENGTH OF STAY (in this place) 3 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 502 Penn St.		
3. NAME OF DECEASED (Type or Print) a. (First) KATE		b. (Middle) MORRIS		c. (Last)
4. DATE OF DEATH		5. SEX female		
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED divorced		8. DATE OF BIRTH March 28, 1884
9. AGE (in years last birthday) 65		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife		10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Cedar County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME unknown
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE L. D. Morris		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. C. R. Leedy, Rte 4, Carthage, Mo.		ADDRESS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Myocarditis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from March 16, 1949, to May 28, 1949, that I last saw the deceased alive on May 28, 1949, and that death occurred at 4:10 a.m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Guy J. Morritt, M.D.		23b. ADDRESS 401 Paris Bldg Joplin Mo		23c. DATE SIGNED 5-28-49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE May 31, 1949		24c. NAME OF CEMETERY OR CREMATORY Park Cemetery
24d. LOCATION (City, town, or county) Carthage, Missouri		24e. (State)		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 5-28-49		25. FUNERAL DIRECTOR'S SIGNATURE Knell Mortuary Carthage, Mo.		ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

49
2
5

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... Robert H. Knell.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4459

P. O. Address Carthage

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.