

FILED NOV 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36016

State File No. _____
Registrar's No. 304

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>	
c. LENGTH OF STAY (in this place) <u>19 Days</u>		d. STREET ADDRESS (If rural, give location) <u>1203 E. Randolph</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home</u>			

3. NAME OF DECEASED a. (First) <u>Henry</u> b. (Middle) <u>ALEXANDER</u> c. (Last) <u>Morris</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 11 1950</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>7 September 1873</u>		9. AGE (In years last birthday) <u>77</u>		10. MONTHS <u>2</u> DAYS <u>4</u> HOURS <u>0</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICAL REMEDIES</u>		
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>GEORGE W. MORRIS</u>		13b. MOTHER'S MAIDEN NAME <u>ELLA STERLING</u>		14. NAME OF HUSBAND OR WIFE <u>LOLA MORRIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JAMES S. MORRIS, GREEN CASTLE, MO.</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute circulatory failure.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
		ANTECEDENT CAUSES MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure.</u>		<u>19 days</u>	
		DUE TO (c) <u>Bronchiogenic Carcinoma.</u>		<u>2 yrs.</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic Carcinoma</u>		<u>2 yrs.</u>	

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) <u>162X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Oct 23, 1950, to Nov 11, 1950, that I last saw the deceased alive on Nov 10, 1950, and that death occurred at 5:40 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Vincent J. Strangis D.O.</u>		23b. ADDRESS <u>KIRKSVILLE, MO. Community Nursing Home</u>		23c. DATE SIGNED <u>Nov 11, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>NOV. 12, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>	
		24d. LOCATION (City, town, or county) (State) <u>MILAN, MISSOURI</u>			

DATE REC'D BY LOCAL REG. <u>11-11-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Glenn E. Kent & Son, Shen City, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

00134

Date Received: NOV 13 1950
DISTRICT HEALTH OFFICE #2
District File Number 11-50-1903
Date Filed: NOV 14 1950

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.

Student
Student Embalmer

Signed Karl P. Fent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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.