

FILED NOV 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39596**

BIRTH NO. _____ REG. DIST. NO. **3574** PRIMARY REG. DIST. NO. **6198** Registrar's No. **52**

1. PLACE OF DEATH
a. COUNTY **Texas**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Texas** b. COUNTY **Texas**

1070
1

c. CITY (If outside corporate limits, write RURAL and give township)
Rural Cass 4th Mo. S.

d. FULL NAME OF HOSPITAL OR INSTITUTION

d. STREET ADDRESS (If rural, give location)
4 mi. E. of Elk Creek Mo.

3. NAME OF DECEASED
a. (First) **Loa** b. (Middle) _____ c. (Last) **MORGAN**

4. DATE OF DEATH (Month) (Day) (Year)
11 1 50

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **widowed**

8. DATE OF BIRTH **May 7, 1893** 9. AGE (In years last birthday) (If under 1 year: Months Days) (If under 24 hrs: Hours Min.)
57 5 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
house wife 10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **Ind.** 12. CITIZEN OF WHAT COUNTRY? **U.S.-A.**

13a. FATHER'S NAME **John Lee** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Chris**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME **Clyde Morgan** ADDRESS **Houston, Mo.**

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Coronary Occlusion**
ANTECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
4201

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE **Gaynell Cunningham** (Degree or title) **Coroner** 23b. ADDRESS **Cass Mo** 23c. DATE SIGNED **11/3/50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **11-4-50** 24c. NAME OF CEMETERY OR CREMATORY **Wheat Grove** 24d. LOCATION (City, town, or county) (State) **Texas Co. Mo**

DATE REC'D BY LOCAL REG. **11-8-50** REGISTRAR'S SIGNATURE **Gaynell Cunningham** 325 25. FUNERAL DIRECTOR'S SIGNATURE **Gaylord O. Elliott** ADDRESS **Houston, Mo.**

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

DIVISION OF HEALTH OF MD.
District No. 5 - Springfield

RECEIVED NOV 14 1950

Dist. File 150-2313

Date Filed 11-27-50

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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston

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.