

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4917**

FILED FEB 16 1953 BIRTH NO. REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **191**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	c. LENGTH OF STAY (in this place) 40 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION 613 1/2 N. 3rd St.		d. STREET ADDRESS (If rural, give location) 613 1/2 N. 3rd St.	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Florence c. (Last) Morton			4. DATE OF DEATH (Month) (Day) (Year) 2 6 1953		
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5 15 1881	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Platteburg - Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Fisher	13b. MOTHER'S MAIDEN NAME Marie Johnson	14. NAME OF HUSBAND OR WIFE John S. Morton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Beatrice King - Omaha - Neb.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency		
	ANTECEDENT CAUSES Morbid 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. 410X		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None made	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) St. Joseph - Buchanan MO
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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?
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22. I hereby certify that I attended the deceased from **Nov 20, 1952**, to **Feb 5, 1953**, that I last saw the deceased alive on **Feb 5, 1953**, and that death occurred at **1:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Flenton W. Landon MD	23b. ADDRESS 224 E. 7th Ave.	23c. DATE SIGNED Feb 9 1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2 9 1953	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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DATE REC'D BY LOCAL REG. Feb 11, 1953	REGISTRAR'S SIGNATURE Carl C. Casper	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William H. Alexander 1602 Mesquite City
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.