

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5603

STATE FILE NUMBER

FILED FEB 28 1957

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 9

Health,
Welfare
Public
Service

300
-56

Use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Versailles 0710</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>309 1/2 Oak</u>			Length of stay in lb <u>Lifetime</u>		d. STREET ADDRESS <u>309 1/2 Oak</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Jane</u> Last <u>Morrow</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1957</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 11, 1871</u>		9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Ottumwa, Iowa</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Bryant</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Louise Morrow</u> Address <u>Thuma, Arizona</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>										
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>332X</u>										
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>			20f. CITY, TOWN, OR LOCATION <u> </u>			COUNTY <u> </u>		STATE <u> </u>		
21. I attended the deceased from <u>2-11-57</u> to <u>2-22-57</u> and last saw her <u>her</u> alive on <u>2-22-57</u> Death occurred at <u>8:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Jack Grunwald</u> (Dofce or title)				22b. ADDRESS <u>Versailles, Mo.</u>				22c. DATE SIGNED <u>2-23-57</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>24 Feb. 57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Versailles, Mo.</u>					
24 FUNERAL DIRECTOR <u>W. F. Kidwell</u> ADDRESS <u>Versailles, Mo.</u>				25. DATE REC'D. BY LOCAL REG. <u>2-25-57</u>				26. REGISTRAR'S SIGNATURE <u>J. B. Nestle</u>					

(Licensed Embalmer's Statement on Reverse Side)

018 2 11

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.....
Signature of Student Embalmer

Signed.....
Raymond C. Linder

Licensed Embalmer No. *461*

P. O. Address *Vermont*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.