

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39313

STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1208

V. S. 300
Rev. 1-57

Securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

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, give TOWNSHIP only) TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.			Length of stay in 1b 38 yrs.		d. STREET ADDRESS 517 1/2 So. 6th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Pearl Middle May Last Morris				4. DATE OF DEATH Month Nov. Day 1 Year 1957					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 23, 1893		9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
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 (City and state or country) Clark Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Lafe Hamilton			13b. MOTHER'S MAIDEN NAME Elanore Elizabeth Mosley			14. NAME OF HUSBAND OR WIFE Bud Morris			
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 Address John Hamilton, St. Joseph, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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.)						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			20d. INJURY OCCURRED WHILE AT <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.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from 10/12/52 to 11/1/57 and last saw her alive on 11/1/57 Death occurred at 2:35 P on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>C. W. Sleazy MD</i>				(Degree or title) Social Welfare Board			22b. ADDRESS 10th & Olive, St. Joseph, Mo.		22c. DATE SIGNED 11/2/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 6, 1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery			23d. LOCATION (City, town, or county) (State) St. Joseph, - Missouri			
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc. St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Nov. 12, 1957		26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>			

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 *Albert E. Harrington*

Licensed Embalmer No. 3258

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.