

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021096

STATE FILE NUMBER

FILED JUN 27 1958 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 413

300
1-57

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Poplar Bluff 01240
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1234 W. Delano		Length of stay in 1b 50 yrs.	d. STREET ADDRESS (If outside, give location) 1234 W. Delano St.
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Iva Jane Morse			4. DATE OF DEATH Month Day Year June 11, 1958		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1897	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
------------------	---------------------------	---	-----------------------------------	---------------------------------------	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cape Girardeau, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME John Thomas Wilson	13b. MOTHER'S MAIDEN NAME Eliza Jane Fairless	14. NAME OF HUSBAND OR WIFE Albert S. Morse
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Albert S. Morse	Address Poplar Bluff, 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 Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	
	DUE TO (c) 4200	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.	
---	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Poplar Bluff, Mo.	COUNTY	STATE
---	--	---	--------	-------

21. I attended the deceased from 5-26-58 to 6-6-58 and last saw her alive on 6-6-58
Death occurred at 9:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Frank E. Dinelli M.D.	(Degree or title)	22b. ADDRESS 215 Oak St., Poplar Bluff, Mo.	22c. DATE SIGNED 6-16-58
---	-------------------	--	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 14, 1958	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	23d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo.
---	----------------------------	---	--

24. FUNERAL DIRECTOR Frank-Cotrell	ADDRESS Poplar Bluff, Mo.	25. DATE RECD. BY LOCAL REG. 6/21/58	26. REGISTRAR'S SIGNATURE H. M. Murrell
---------------------------------------	------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

890

RECEIVED

JUN 24 1958

BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Charles E. Mungler*

Licensed Embalmer No. *4877*

P. O. Address *Poplar Bl.*

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.