

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033387  
STATE FILE NUMBER

Registration District No. 176 Primary Registration District No. 4278 Registrar's No. 22

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Lawrence</u>                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Miller</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Miller</u>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION     |  | Length of stay in 1b<br><u>Native</u>   | d. STREET ADDRESS (If outside, give location)<br><u>H4 39</u>                         |
|  |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Kenneth</u> Middle <u>Charles</u> Last <u>Morgan</u>           |                                  |   | 4. DATE OF DEATH<br>Month <u>9</u> Day <u>17</u> Year <u>1958</u>   |  |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9-5-1906</u>                                 | 9. AGE (In years last birthday)<br><u>52</u> | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>12</u> Hours <u>0</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Fiberist</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>Lawrence Co. O</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                            |

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| 13a. FATHER'S NAME<br><u>Ott Morgan</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Lola Connell</u> |   | 14. NAME OF HUSBAND OR WIFE<br><u>Thma Morgan</u> |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no none</u> |  | 16. SOCIAL SECURITY NO.<br><u>490-28-0147</u>    | 17. INFORMANT<br>Address <u>Mrs. Thma Morgan Miller Mo.</u> |   |  |

|   |                                       |   |
|---|---------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute circulatory failure</u> |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>Coronary thrombosis</u> |   |
|   | DUE TO (c) <u>4201</u>                |   |
| 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?<br>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.)<br><u>DOA at office</u> |   |  |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____ 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 _____ to _____ and last saw her alive on _____<br>Death occurred at <u>3:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |                                    |  |
| 22a. SIGNATURE (Degree or title)<br><u>Hugh Baker</u>  |  | 22b. ADDRESS<br><u>Miller, Missouri</u> |  | 22c. DATE SIGNED<br><u>9-20-58</u> |  |

|  |  |                               |                              |  |  |   |   |  |
|--|--|-------------------------------|------------------------------|--|--|---|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> |  | 23b. DATE<br><u>9-21-1958</u> |                              | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Pleasant Grove S. of Miller Mo.</u> |  | 23d. LOCATION (City, town, or county) (State) |   |  |
| 24. FUNERAL DIRECTOR<br><u>E.P. Seiman</u>                 |  |                               | ADDRESS<br><u>Miller Mo.</u> |  | 25. DATE RECD. BY LOCAL REG.<br><u>9-20-58</u> |   | 26. REGISTRAR'S SIGNATURE<br><u>W &amp; Beccary</u> |  |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57  
1

580

JAN 21 1966

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 *S. R. Seiman*.....

Licensed Embalmer No. *3297*.....

P. O. Address *Miller M*.....

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.