

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043894

STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 159 Primary Registration District No. Registrar's No. 89

300
-57

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mound City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Graham Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kline Nursing Home 1yr 4 mos		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MILLICENT EVELYN MORRIS			4. DATE OF DEATH Month Day Year 12 25 1958		
--	--	--	---	--	--

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 9 12 1881	9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY home-own	11. BIRTHPLACE (City and state or country) Logansport, Ind.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	--

13a. FATHER'S NAME William Grace	13b. MOTHER'S MAIDEN NAME Nancy Taylor	14. NAME OF HUSBAND OR WIFE Wm.H.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. unknown	17. INFORMANT Address Mrs Grace Combs, Mound City, 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) _____ DUE TO (b) Cerebral hemorrhage 2 weeks DUE TO (c) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 331X		

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 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	--

21. I attended the deceased from about 1 year 12 25 58 and last saw her alive on Dec 25-1958 Death occurred at 12:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) F E Hogan M.D.	22b. ADDRESS Mound City, Mo	22c. DATE SIGNED 12/27/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/29/1958	23c. NAME OF CEMETERY OR CREMATORY Graham Cemetery	23d. LOCATION (City, town, or county) (State) Graham Mo.
--	--------------------------------	--	--

24. GENERAL DIRECTOR Dr. C. H. Johnson	ADDRESS Manlyville, Mo.	25. DATE RECD. BY LOCAL REG. 12/27/1958	26. REGISTRAR'S SIGNATURE James H. Crawford
--	-----------------------------------	---	---

(Licensee's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *G. M. Atkinson*

Licensed Embalmer No. *3279*

P. O. Address *Maryville*

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.