

Health,  
Welfare  
Public  
Service

FILED MAR 23 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008568

STATE FILE NUMBER

XC-430627  
REG.#A135

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 117

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>MISSOURI</b> b. COUNTY <b>MISSISSIPPI</b> )		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>CHARLESTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS HOSPITAL</b>		Length of stay in lb <b>42 DAYS</b>	d. STREET (If outside, give location) ADDRESS <b>811 EAST CYPRESS ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>ROSE</b> Last <b>MORRIS</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-87</b>		9. AGE (In years last birthday) <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>		11. BIRTHPLACE (City and state or country) <b>DORCHESTER, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>WILLIAM E. MORRIS</b>		13b. MOTHER'S MAIDEN NAME <b>LEANORA HALTERMAN</b>	
14. NAME OF HUSBAND OR WIFE <b>NOT APPLICABLE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. CHRONIC CONGESTIVE HEART FAILURE.</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } <b>DOE TO (b) a. Rheumatic Heart Disease with mitral stenosis and insufficiency and aortic stenosis and insufficiency.</b> <b>DOE TO (c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>23 Years</b>	
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 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 <b>VA</b>		20g. COUNTY		20h. STATE	
21. I attended the deceased from Death occurred at <b>1:50 PM</b> on <b>Jan. 22, 1959</b> to <b>March 5, 1959</b>		21a. SIGNATURE <b>Robert S. Cohen</b>		21b. ADDRESS <b>VA Hospital, Poplar Bluff, Mo.</b>	
21c. DATE SIGNED <b>3/6/59</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE <b>3-8-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. CEMETERY</b>		22d. LOCATION (City, town, or county) <b>CHARLESTON, Mo.</b>		22e. (State)	
24. FUNERAL HOME <b>LEE FUNERAL CHAPEL Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3/14/59</b>		26. REGISTRAR'S SIGNATURE <b>R. Muette</b>	

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

*John F. ...*

Licensed Embalmer No. 3851

P. O. Address Charleston,

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.