

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013919

STATE FILE NUMBER

FILED APR 23 1959

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 261

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Higginsville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lexington</u> <u>05420</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Schenker Rest Home</u>		Length of stay in 1b <u>3 wks</u>	d. STREET ADDRESS (If outside, give location) <u>1717 Bloom Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Arna</u> Middle <u>Lorene</u> Last <u>Morris</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1921</u>	9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Carl Jeude</u>	13b. MOTHER'S MAIDEN NAME <u>Salma Kemner</u>	14. NAME OF HUSBAND OR WIFE <u>Elmer Morris</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Selma Jeude, Lexington, Missouri</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Ductal carcinoma rt. breast</u>		<u>3 or 4 yrs.</u>
	DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple pathological fractures</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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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.)
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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 COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw her ^{her} _{been} alive on _____ Death occurred at <u>4:00 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert B. Best, M.D.</u>	22b. ADDRESS <u>Reginville, Mo.</u>	22c. DATE SIGNED <u>4-18-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah</u>	23d. LOCATION (City, town, or county) (State) <u>Lexington, Missouri.</u>
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24. FUNERAL DIRECTOR <u>Forest F. Temple, Lexington</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>April 20, 59</u>	26. REGISTRAR'S SIGNATURE <u>Lucie Gordon Jordan</u>
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(Licensed Embalmer's Statement on Reverse Side)

Robert B. Best M.D.

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 Leo Mylan

Licensed Embalmer No. 2983
P. O. Address Leungton, Miss

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.