Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014080

STATE FILE NUMBER

FILED APR 21 1959 Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 60

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Macon — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Samaritan Hosp. — Length of stay in lb 1 Hour

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Shelby
c. CITY OR TOWN Shelbina 1020 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 304 Reid St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Kriemhild Middle Last Morrison

4. DATE OF DEATH Month Day Year April 1, 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH April 1, 1959

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 1 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Macon, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Bobby H. Morrison

13b. MOTHER'S MAIDEN NAME Dorothy Rieffenberg

14. NAME OF HUSBAND OR WIFE - - - - - - - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----------

16. SOCIAL SECURITY NO. -------

17. INFORMANT Address Mr. Bobby Morrison, Shelbina, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxemia — INTERVAL BETWEEN ONSET AND DEATH 30 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Premature Birth — 6 months pregnancy.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7625

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 April 1, to April 1, 1959 and last saw her alive on April 1, 1959
Death occurred at 10:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Roy D Madden DO 2

22b. ADDRESS Macon, Missouri

22c. DATE SIGNED 4/4/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 4/3/1959

23c. NAME OF CEMETERY OR CREMATORY Shelbina Cemetery

23d. LOCATION (City, town, or county) (State) Shelbina, Missouri

24. FUNERAL DIRECTOR ADDRESS Hayes Funeral Home, Shelbina, Mo.

25. DATE RECD. BY LOCAL REG. 4/5/59

26. REGISTRAR'S SIGNATURE Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Date Filed 4-20-57

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 .....Paul E. Hayes.....

Licensed Embalmer No. 4461

P. O. Address .....Shelbina.....

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.