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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021003

STATE FILE NUMBER

FILED JUN 30 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 694

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Springfield — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1348 N. Broadway — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Greene
c. CITY OR TOWN: Springfield — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 0396 1348 N. Broadway — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: ZACHARIAH Middle: LEE Last: MORRIS

4. DATE OF DEATH: Month: June Day: 25, Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 29 January 1876
9. AGE (In years last birthday): 83 — 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): Railroad Employee
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Frank Morris
13b. MOTHER'S MAIDEN NAME: Mattie Bridges
14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Ruth Snyder(Daughter) Address: Springfield, 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): Generalized Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4500
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

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 6-19-59, to 6/25/59 and last saw ~~him~~ him alive on 6-21-59
Death occurred at 9:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D Dean Cunningham (Degree or title)
22b. ADDRESS: Spgfd. Medical Bldg. Springfield, Missouri
22c. DATE SIGNED: 6-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-27-59
23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: J.W.KLINGNER & CO. ADDRESS: Springfield, Mo.
25. DATE RECD. BY LOCAL REG.: 6-26-59
26. REGISTRAR'S SIGNATURE: Effie B Melton

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 J. B. Klingner .....

Licensed Embalmer No. 3358

P. O. Address .....

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.