

# VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-034981

**FILED VS SEP 22 1959** 360

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 6225 Registrar's No. 153

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>VERMONT</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u> Length of stay in 1b <u>21 Y. 2 M. 26 D.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSPITAL #3, NEVADA, MO</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u> c. CITY OR TOWN <u>JOPLIN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2229 MOFFETT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LAURA</u> Middle <u>-</u> Last <u>MORRIS</u>			<b>4. DATE OF DEATH</b> Month <u>SEPT</u> Day <u>11</u> Year <u>1959</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JULY 7, 1938</u>	<b>9. AGE (last birthday)</b> <u>52</u>	<b>IF UNDER 1 YEAR</b> Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	<b>IF UNDER 24 HR</b> Hours <u>-</u> Min. <u>-</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>SARCOXIE, MO</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u>	
<b>13a. FATHER'S NAME</b> <u>CHARLES MORRIS</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>EDNA COUSER</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>-</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> Address <u>STATE HOSPITAL #3 NEVADA, MO</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> DUE TO (b) <u>PHLEBITIS LEFT LEG</u> DUE TO (c) <u>ANKLE FRACTURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause - last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>  <u>2 MONTHS</u>  <u>4 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>EPILEPSY MANY YEARS</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <del>_____</del>					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year <del>_____</del>	<del>_____</del>						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <del>_____</del>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <del>_____</del>				
<b>21. I attended the deceased from</b> <u>JUNO-16-1938</u> to <u>9-11-1959</u> and last saw her/him alive on <u>9-11-1959</u> Death occurred at <u>2:20</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>George Esker M.D.</u>				<b>22b. ADDRESS</b> <u>STATE HOSPITAL NEVADA, MO</u>		<b>22c. DATE SIGNED</b> <u>9-11-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>Sept. 12, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Park</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Joplin, MO</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Thornhill - Dillon Joplin, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-17-1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Anna E. Perry</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Robert C. Roller

Licensed Embalmer No. 5062

P. O. Address Agulie, W.

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.