

MINNESOTA DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038779

FILED VS. NOV. 16 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 337

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY ADAIR				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY JEFFERSON				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE		Length of stay in 1b		c. CITY OR TOWN FAIRFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAUGHLIN HOSPITAL & CLINIC			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAE Middle B. Last MORRISON				4. DATE OF DEATH Month NOVEMBER Day 12 , Year 1959				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/16/89	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSIC TEACHER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME BEN TRON			13b. MOTHER'S MAIDEN NAME MINNIE BELL JONES			14. NAME OF HUSBAND OR WIFE BERT W. MORRISON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT BERT W. MORRISON			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMACIATION AND DEBILITATION DUE TO (b) WIDESPREAD METASTATIC PAPILLARY DUE TO (c) CYSTADENOCARCINOMA OF OVARY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH MAY 1958	
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 a.m. p.m.	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from OCT 17 1959 to NOV 12 1959 last saw her ^{her} _{him} alive on NOV 11 1959 Death occurred at 6:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Carl Laughlin, M.D.				22b. ADDRESS Fairfield, Iowa			22c. DATE SIGNED 11-12-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-12-1959	23c. NAME OF CEMETERY OR CREMATORY FELL CEMETERY			23d. LOCATION (City, town, or county) LIBERTYVILLE, IOWA		
24. FUNERAL DIRECTOR Weston Behner, Fairfield, Iowa				25. DATE RECD. BY LOCAL REG. 11-12-1959		26. REGISTRAR'S SIGNATURE Doris W. Rathoff		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EARL LAUGHLIN, JR. D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219
P. O. Address Kirkville

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.