URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-038780

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 335

ENDED

1. PLACE OF DEATH
a. COUNTY ADAIR
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) NURSING HOME # 1 — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ADAIR
c. CITY OR TOWN BRASHEAR — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 3½ mi N. — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle ALLEN Last MORROW

4. DATE OF DEATH Month NOV. Day 8 Year 1959

5. SEX MALE

6. COLOR OR RACE CAUCASION

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH MAY 21, 1886

9. AGE (last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY FARM

11. BIRTHPLACE (City and state or country) ADAIR COUNTY, MO.

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

13a. FATHER'S NAME A.T. MORROW

13b. MOTHER'S MAIDEN NAME ANNA LOWE

14. NAME OF HUSBAND OR WIFE FANNIE POWELL

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

16. SOCIAL SECURITY NO. 486-12-5173

17. INFORMANT RUSSELL MORROW Address BRASHEAR, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Medullary Paralysis — INTERVAL BETWEEN ONSET AND DEATH hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Thrombotic Encephalomalacia — weeks

DUE TO (c) Cerebral Arteriosclerosis — years

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. ☐ Yes ☐ No ☐ Unknown

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 Sept 1, 1959, to Nov 8, 1959 and last saw her/him alive on Nov 4, 1959

Death occurred at 4:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William F. Bergen D.O.

22b. ADDRESS Kirksville

22c. DATE SIGNED 11/10/59

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

23b. DATE Nov. 11, 1959

23c. NAME OF CEMETERY OR CREMATORY SABBATH HOME

23d. LOCATION (City, town, or county) (State) 3 mi N.W. BRASHEAR, MO

24. FUNERAL DIRECTOR Kelley Rogers ADDRESS Brashear, Mo.

25. DATE RECD. BY LOCAL REG. 11-12-1959

26. REGISTRAR'S SIGNATURE Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

WILLIAM F. BERGEN, 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 n

or by _____, Student Embalmer No._____(

working under my personal supervision.

Student_____ Signed Robert B. Davis

Signature of Student Embalmer

Licensed Embalmer No. 4219

P. O. Address Kittabelle, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.