

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-038932**

**FILED VS NOV 7 1960**

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 127

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Length of stay in 1b <b>45 yrs.</b>	c. CITY OR TOWN <b>Brookfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>414 Peck St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>414 Peck St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>JODIE NORINE MORRISON</b>			4. DATE OF DEATH Month Day Year <b>Oct. 28 1960</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-01</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Dalton, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>Thomas Coleman</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy C. Stuckey</b>		14. NAME OF HUSBAND OR WIFE <b>Earl Morrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Earl Morrison Brookfield, Missouri</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic interstitial nephritis</b>	<b>8</b>	
	DUE TO (c) <b>Arteriosclerosis with Hypertension</b>	<b>10</b>	
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

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 <b>Brookfield Mo</b>	COUNTY <b>Missouri</b>	STATE
21. I attended the deceased from <b>Jan 1950</b> to <b>Oct 28, 1960</b> and last saw her alive on <b>10-28-60</b> Death occurred at <b>1:45 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Bob Smith MD</b> (Degree or title)	22b. ADDRESS <b>Brookfield Mo</b>	22c. DATE SIGNED <b>10-29-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Brookfield Missouri</b>

24. FUNERAL DIRECTOR <b>Wright Funeral Home</b>	ADDRESS <b>Brookfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-29-60</b>	26. REGISTRAR'S SIGNATURE <b>Katharine Johnson</b>
--	-----------------------------------	---	---

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

VS  
MAY 8  
1968

**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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield

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