

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001179

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DATE AMENDED  
1  
6  
DATE AMENDED  
INSTEAD OF  
0  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
ITEM NO. SHOULD READ  
BY AFFIDAVIT OF

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 15

FILED VS JAN 30 1961

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>West Plains</b>		Length of stay in 1b <b>3 1/2 Hurs</b>	c. CITY OR TOWN <b>Willow Springs,</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>Memorial Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Gen. Delivery</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Infant</b> Middle <b>(Baby Girl)</b> Last <b>MORRIS</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>19,</b> Year <b>1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>30</b> Min. <b>30</b>
13a. FATHER'S NAME <b>Chalmer B. Morris</b>		13b. MOTHER'S MAIDEN NAME <b>Gail Longnecker</b>	11. BIRTHPLACE (City and state or country) <b>West Plains, Mo.</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>	12. CITIZEN OF WHAT COUNTRY <b>USA</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>Pulmonary atelectasis</b>		14. NAME OF HUSBAND OR WIFE <b>Chalmer Morris, Willow Spgs., Mo.</b>	
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 <b>3 hr. 30 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Premature baby</b>			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 <b>4</b> a.m. <b>A.M.</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>West Plains, Mo.</b>
21. I attended the deceased from <b>1/19/61</b> to <b>1/19/61</b> and last saw her/him alive on <b>1/19/61</b> Death occurred at <b>4 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		20f. COUNTY <b>Howell</b> STATE <b>Mo.</b>	
22a. SIGNATURE <i>C. F. Callihan</i> (Degree or title) <b>C. F. Callihan, M.D.</b>		22b. ADDRESS <b>West Plains, Mo.</b>	22c. DATE SIGNED <b>1/20/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/20/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Little Zion</b>	23d. LOCATION (City, town, or county) <b>Twin Bridges, Mo.</b>
24. FUNERAL DIRECTOR <b>Burns Funeral Home, Willow Spgs., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-25-61</b>	26. REGISTRAR'S SIGNATURE <i>Beatrice Cook</i>

**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.

**" NO EMBALMING "**

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.