

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-61-024165**

STATE FILE NUMBER

AMENDED

Registration District No. **042**

Primary Registration District No. **1000**

Registrar's No. **798**

**FILED AUG 14 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **C.F. COSSINS, M.D.** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Atchison</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>45 yrs.</b>		c. CITY OR TOWN <b>Skidmore</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Drucilla</b> Middle <b>MORSE</b> Last <b>MORSE</b>				4. DATE OF DEATH Month <b>8</b> Day <b>4</b> Year <b>61</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/3/82</b>		9. AGE (last birthday) <b>79</b>		
						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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (City and state or country) <b>Nebraska Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>James Morse, dec.</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 <b>Mrs. Grace Hardie, Des Moines, Ia.</b>				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) <b>Rectal hemorrhage</b>								INTERVAL BETWEEN ONSET AND DEATH <b>a few hrs.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>C. A. of Rectum</b>								<b>1 yr.</b>		
DUE TO (c) <b>Arteriosclerosis</b>								<b>10 yrs.</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 checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>8/4/61</b> to <b>8/4/61</b> and last saw her <b>8/4/61</b> Death occurred at <b>7:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>C.F. COSSINS, M.D.</b>				22b. ADDRESS <b>St. Joseph State Hospital</b>				22c. DATE SIGNED <b>8-4-1961</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Aug. 7, 61</b>		23c. NAME OF CEMETERY OR CREMATOR <b>I.O.O.F. Cemetery n Quitman, Mo.</b>		23d. LOCATION (City, town, county)				
24. FUNERAL DIRECTOR <b>Price Funeral Home, Maryville, Mo.</b>				25. DATE REC'D. BY LOCAL REG. <b>Aug 7, 1961</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>				

**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 Clum M. Price

Licensed Embalmer No. 1F22

P. O. Address Maryville Mo

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.