

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035726

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 302

FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kirksville Osteopathic</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>714 South 5th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Oliver</u> Last <u>Morehead</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>18,</u> Year <u>1961</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1878</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	---	--	----------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (City and state or country) <u>Lexington, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	--	---

13a. FATHER'S NAME <u>Dewitt Clinton Morehead</u>	13b. MOTHER'S MAIDEN NAME <u>Kathryn Hulse</u>	14. NAME OF HUSBAND OR WIFE <u>May Ford Morehead</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT Address <u>Mrs. May Ford Morehead, 714 S. 5th Kirksville</u>
---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Circulatory collapse</u>		<u>1 1/2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial infarction</u>	<u>4 days</u>
	DUE TO (c) <u>arteriosclerotic heart disease</u>	<u>unknown years</u>
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"/> N- <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 <u>1:25</u> Month, Day, Year <u>October 15, 1961</u> a.m. p.m.	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 COUNTY STATE
---	---	--	---

21. I attended the deceased from <u>October 15, 61</u> to <u>Oct 18, 1961</u> and last saw <u>him</u> alive on <u>Oct 18, 1961</u> Death occurred at <u>1:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
---	--	--

22a. SIGNATURE (Degree or title) <u>Richard H. Turner D.D.</u>	22b. ADDRESS <u>Kirksville Mo.</u>	22c. DATE SIGNED <u>10/21/61</u>
---	---------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 20, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bullion</u>	23d. LOCATION (City, town, or county) (State) <u>Adair County, Kirksville, Mo.</u>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Dee Riley Funeral Home, W.K. Jackson</u> <u>W.K. Jackson</u> (Licensed Embalmer's Statement on Reverse Side)	25. DATE RECD. BY LOCAL REG. <u>10-23-1961</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>
--	---	--

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

RICHARD H. TURNER, D.D.

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 Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Killsville

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.