

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037610

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 126

**FILED NOV 8 1961**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>LINCOLN</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BEDFORD TOWNSHIP</u>	Length of stay in 1b <u>3 HOURS</u>	c. CITY OR TOWN <u>WINFIELD</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>L. C. MEM. HOSP.</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>DELBERT</u> Last <u>MORGAN</u>	<b>4. DATE OF DEATH</b> Month <u>OCT.</u> Day <u>29</u> Year <u>1961</u>
---	---

<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-25-16</u>	<b>9. AGE (last birthday)</b> <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------------------	---	---	---	--	--	--

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

<b>13a. FATHER'S NAME</b> <u>JAMES H. MORGAN</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>NELLIE CRUME</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>HELEN (POWELSON)</u>
---	---	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	<b>17. INFORMANT</b> Address <u>HELEN MORGAN WINFIELD, Mo.</u>
---	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female</b> was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
--	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
--	------------------------

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
---	---	--

21. I attended the deceased from 10-28-61 to 10-29-61 and last saw her alive on 10-29-61  
 Death occurred at 3:42 A m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Joseph E. Speer, DO</u>	<b>22b. ADDRESS</b> <u>Winfield, Mo</u>	<b>22c. DATE SIGNED</b> <u>10-30-61</u>
---	--	--

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE</b> <u>10-31-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>THORNHILL</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>RFD TROY, Mo -</u>
---	-------------------------------------	---	---

<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>O. C. Ricks ELSBERRY, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-30-1961</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Charlotte Leek</u>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 2 AON

NOV 14 1961

DEC 7 1961

**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 *[Handwritten Signature]*

Licensed Embalmer No. 4012

P. O. Address Elaberry, N.J.

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.