

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-039865

STATE FILE NUMBER

Registration District No. 351 Primary Registration District No. 4515 Registrar's No. 56

AMENDED

FILED OCT 18 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>10 da.</u>	c. CITY OR TOWN <u>Humphreys</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S.c.m. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>BERTRAM</u> Last <u>MORROW</u>	4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1961</u>
---	---

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>9-12-1886</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
-----------------	---------------------------	---	-----------------------------------	----------------------------------	--	--

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

13a. FATHER'S NAME <u>Wm Morrow</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Morrow</u>
-------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT Address <u>Mr Ruth Morrow Humphreys Mo</u>
---	----------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>	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.) <u></u>
--	---	--

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

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.) <u></u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u>
---	--	---

21. I attended the deceased from 9-25-1961 to 10-5-61 and last saw him alive on 10-4-61
Death occurred at 3:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>V. Robinson D.O.</u>	22b. ADDRESS <u>Milan, Mo</u>	22c. DATE SIGNED <u>10-5-61</u>
--	-------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-6-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Humphreys Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Rayne General Home Salt Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>
--	--	---

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.