

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044370

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 137 Primary Registration District No. _____ Registrar's No. 289

FILED JAN 2 1962

DATE AMENDED
2/8/62

INSTEAD OF
Arteriosclerotic heart disease Awaiting pathological report

ITEM NO. SHOULD READ
186 Arteriosclerotic heart disease

BY AFFIDAVIT OF attending physician

1. PLACE OF DEATH a. COUNTY <u>Henry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairview Twp</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 Mi W of Deepwater Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u> c. CITY OR TOWN <u>Deepwater Rural Route # 2</u> d. STREET ADDRESS (If outside, give location) <u>RR # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Roy</u> Last <u>Morrison</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>19</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>Jan 26, 1894</u>
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>Decaturville, Mo</u>	9. AGE (last birthday) <u>67</u>
11. BIRTHPLACE (City and state or country) <u>Decaturville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Frank M. Morrison</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Rogers</u>	
14. NAME OF HUSBAND OR WIFE <u>Gracie Morrison</u>		17. INFORMANT Address <u>Clyde Morrison Clinton, Mo</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>		16. INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Awaiting pathological report</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m.			
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 <u>12-1-61</u> to <u>12-19-61</u> and last saw him alive on <u>12-19-61</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James O. Smith MD</u> (Degree or title)		22b. ADDRESS <u>Clinton, Mo</u>	22c. DATE SIGNED <u>12-29-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/22/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Johnson Co Memorial Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Johnson Co, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Sickman & Dunning F H Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 29, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Biggers</u>

JAN 4 1962

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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 *R. L. Manning*

Licensed Embalmer No. 4910

P. O. Address Cleaton Me

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.