

# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-026045

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 388

JUL 23 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |  |  |   |  |  |
|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)                                  |   |  |  |
| a. COUNTY<br><u>Boone</u>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><u>Columbia</u>   |  | a. STATE<br><u>Missouri</u>  |   | b. COUNTY<br><u>Boone</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>408 West Broadway</u>                            |  | Length of stay in 1b<br><u>15 Years</u>   |  | c. CITY OR TOWN<br><u>Columbia</u>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
|   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS<br><u>408 West Broadway</u>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)   |  |   |  | 4. DATE OF DEATH   |   |  |  |
| First<br><u>ANNA</u>  |  | Middle<br><u>LOUISE</u>   |  | Last<br><u>MORRIS</u>  |   | Month Day Year<br><u>July 11, 1962</u>                                     |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-17-1865</u>               | 9. AGE (last birthday)<br><u>97</u>  | IF UNDER 1 YEAR<br>Months Days Hours Min.             |  | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u>                         |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Versailles, Mo.</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                               |  |
| 13a. FATHER'S NAME<br><u>Daniel Beyer</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Mary (unknown)</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>John Wm. Morris</u> |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                 |  |   | 16. SOCIAL SECURITY NO.<br><u>None</u>             |  | 17. INFORMANT<br><u>J.U. Morris, Columbia, Mo.</u>    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                              |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <u>myocarditis, chronic</u>   |  |   |  |  |   |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis general</u> |  |   |  |  |   |  |  |
| (c) <u>Carcinoma left breast metastatic</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>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>1961</u> to <u>July 11, 1962</u> and last saw her alive on <u>July 4, 1962</u>                    |  |   |  | Death occurred at <u>10:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |
| 21a. SIGNATURE (In blue or title)<br><u>James R. Palmer M.D.</u>  |  |   |  | 21b. ADDRESS<br><u>Columbia Mo.</u>  |   | 21c. DATE SIGNED<br><u>July 2, 1962</u>                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>July 14, 1962</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Zion Cemetery</u>   |   | 23d. LOCATION (City, town, or county) (State)<br><u>Lincoln, Mo.</u>       |  |
| 24. FUNERAL DIRECTOR<br><u>Parker Funeral Service, Columbia, Mo.</u>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>July 14, 1962</u>   |   | 26. REGISTRAR'S SIGNATURE<br><u>Mrs R.E. Palmer</u>                        |  |

(Licensed Embalmer's Statement on Reverse Side)

**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 George P. Kerby

Licensed Embalmer No. 16752

P. O. Address Columbia, 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.