

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035851

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 410

FILED SEP 25 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 10M; 16days	c. CITY OR TOWN Poplar Bluff Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1232 Delano Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES MARSHALL MORGAN			4. DATE OF DEATH Month Day Year September 12, 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1886
9. AGE (last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min. 9 10	IF UNDER 24 HR Hours Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Vienna, Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James M. Morgan	
13b. MOTHER'S MAIDEN NAME Martha Hartzel		14. NAME OF HUSBAND OR WIFE Naomi Dell Morgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Records, State Hosp. #1, Farmington, Mo.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - - - - -			INTERVAL BETWEEN ONSET AND DEATH Abt. 6 das.
DUE TO (b) Arteriosclerotic Heart Disease - - - - -			Unknown.
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain brain syndrome with cerebral arteriosclerosis.			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.)	
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 August 24, 1962 to Sept. 12, 1962 and last saw him alive on Sept. 12, 1962		Death occurred at 7:45 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) John C. Brennan M.D.		22b. ADDRESS State Hospital No. 4, Farmington, Missouri	22c. DATE SIGNED 9-12-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-15-62	23c. NAME OF CEMETERY OR CREMATORY Kinsey Cemetery	23d. LOCATION (City, town, or county) (State) Near Poplar Bluff, Missouri
24. FUNERAL DIRECTOR Greer-Croy and Fitch, Poplar Bluff, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 23, 1962	26. REGISTRAR'S SIGNATURE Ether Rudloff

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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 *Frank C. Dugal*

Licensed Embalmer No. 4170

P. O. Address Farmington 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.

Frank C. Dugal