

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026837

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 113

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 1 1963

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Marshall</u>		Length of stay in 1b <u>6 weeks</u>	c. CITY OR TOWN <u>Slater</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Slater</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Cleveland</u> Last <u>Morton</u>			4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1963</u>		
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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>10-22-1884</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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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>agricultural</u>	11. BIRTHPLACE (City and state or country) <u>Warrensburg, Mo. U. S. A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>A. James Morton</u>	13b. MOTHER'S MAIDEN NAME <u>Anne Elizabeth Downs</u>	14. NAME OF HUSBAND OR WIFE <u>Anna May Meier Morton</u>
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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. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT <u>Mrs. Charles Morton Slater, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>		
DUE TO (b) <u>Arterio-sclerotic heart disease</u>		
DUE TO (c)		

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
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year	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 <u>Slater</u>	COUNTY <u>Saline</u>	STATE <u>Missouri</u>
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21. I attended the deceased from Apr. 14, 1962 to June 22, 1963 and last saw him alive on June 21, 1963
Death occurred 5:50pm Slater, Missouri on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. Saliken, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Marshall, Mo.</u>	22c. DATE SIGNED <u>6-24-63.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>June 24, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri</u>
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24. FUNERAL DIRECTOR <u>Braun Funeral Home</u>	ADDRESS <u>Slater, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>6-24-'63</u>	26. REGISTRAR'S SIGNATURE <u>Cecil L. Reed</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59
10971
20970
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4 0
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7 0
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942.00
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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

JUL 8 1966

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 Robert D. Beaman

Licensed Embalmer No. 5183

P. O. Address: Slater, 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.