

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040827
STATE FILE NUMBER

NOT WRITE
THIS STUD

AMENDED

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 197

VS 300
Rev. 4/59

10981

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Pemiscot</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hayti</u>		c. CITY OR TOWN <u>Caruthersville, Mo</u>	
Length of stay in lb <u>18 months</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pemiscot Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Hy U west</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Clyde Leon Morris</u>			4. DATE OF DEATH Month Day Year <u>Oct. - 8 - 1963</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>Dec. 8, 1889</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	11. BIRTHPLACE (City and state or country) <u>Greenfield Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Ewing A. Morris</u>		13b. MOTHER'S MAIDEN NAME <u>Bellzora S. Morris</u>	14. NAME OF HUSBAND OR WIFE <u>Alice Morris</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes #1</u>		17. INFORMANT Address <u>Alice Morris Caruthersville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC 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
19. WAS AUTOPSY PERFORMED? YES <input 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 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	COUNTY STATE
21. I attended the deceased from <u>10-59</u> to <u>10-63</u> and last saw him alive on <u>10-8-63</u>			
Death occurred at <u>10:30 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Alan Rubin M.D.</u>		22b. ADDRESS <u>Caruthersville, Mo.</u>	22c. DATE SIGNED <u>10-17-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 10, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Little Prairie</u>	23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>LaForge Und. Co. Caruthersville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte E. Sloan</u>

OCT 24 1963

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

Noel C. Deane

Licensed Embalmer No.

3941

P. O. Address

*Cantrell
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.