

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 27 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12622
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 837
 (b) Township Castor Primary Registration District No. 6099 Registered No. _____
 (c) City or Bloomfield, Mo. (d) Street No. 2 St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wilmer H. Morris
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) Beatris Morris

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) September 18, 1912

7. AGE YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>27</u>	<u>5</u>	<u>27</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

FATHER

13. NAME M. J. Morris

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER

15. MAIDEN NAME Nora Ball

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Nora Stroup
(ADDRESS) Bloomfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bloomfield Cem DATE March 6, 1940

19. FUNERAL DIRECTOR (NAME) Land's Funeral Service
(ADDRESS) Campbell, Mo.

20. FILED _____ 19 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 5, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 7, 1940, to Oct 15, 1940
 I last saw him alive on Feb 15, 1940 Death is said to have occurred on the date stated above, at 7:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Tuberculosis of the Respiratory System
 Date of onset Oct 1939

Other contributory causes of importance:
72

Name of operation Neph Date of _____
 What test confirmed diagnosis? Spurium Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 (Signed) W. H. Morris, M. D.
 (Address) Bloomfield

RECEIVED

District Health Officer No. 2

License No. 440-9

Date 4/9/4

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 12622

Registration District No. 837

Primary Registration District No. 6099

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Castro
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days) (Specify whether

3. (a) PRINT FULL NAME Wilmer H Harris

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 27 Months 5 Days 27 If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Apr. 13, 1946 (b) Loonie Purnch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County.....
(c) City or town Hideon
(If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 5
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature H. H. Harris (M. D. or other)

Address Bloomfield State Mo.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1940
S-12622