

FILED OCT 23 1940

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

32908
Do not use this space.

1. PLACE OF DEATH
(a) County Rutnam 20 Registration District No. 117
(b) Township Madison Primary Registration District No. 4429
(c) City Lucerne or Lucerne (d) Street No. _____ 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. (If How long in U. S., if of foreign birth? yrs. mos. ds.)
2. PRINT FULL NAME Patsy Ann 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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
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) Lucerne Mo
13. NAME Cecil S. Morris
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bethlehem Iowa
15. MAIDEN NAME Dois Lutz
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russell Minnesota
17. INFORMANT (ADDRESS) Mrs. C. S. Morris Lucerne Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE 9/17/40 Lucerne
19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____
20. FILED 9/17 19 40 E. Studabaker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 17 1940
22. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1940 to Sept 17 1940
I last saw her on Sept. 17 1940 Death is said to have occurred on the date stated above, at 3:00 pm.
The principal cause of death and related causes of importance were as follows:
unknown from history; possibly pneumonia
Date of onset 169
Other contributory causes of importance: Prematurity of 2 months
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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? 3
If so, specify _____
(Signed) John A. Puhalevich M. D.
Lucerne, Missouri

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED

District Health Officer No. 10

District File Number 10 70 - 1861

Date Filed OCT 8 1940

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 conform 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

State File No. **32908**

Registration District No. **717**

Primary Registration District No. **4429**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Putnam**
(b) City or town **Lucerne**
(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)

3. (a) PRINT FULL NAME **Patsy Ann Morris**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Inf**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **July 7 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 0 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) **7/17/40** (b) **E. Steudabaker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Putnam**
(c) City or town **Lucerne**
(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 **Sept** day **7**
year _____ hour _____ minute _____ M.

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

Immediate cause of death **Unknown from history probably pneumonia**

Due to **# Bronchial #**

Due to _____
Other conditions **Prematurity**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **1070**

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

