V. S. No. 2
50M—9,4-41
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40512

FILED JAN 11 1943

Registration District No. 74 — Primary Registration District No. 3012 — Registrar's No. 198

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 9 mos. 4 days (Specify whether years, months or days)
In this community: 9 mos. 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Illinois (b) County: [illegible]
(c) City or town: Quincy (If outside city or town limits, write "RURAL")
(d) Street No.: S. & S. HOME (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 2

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3. (a) PRINT FULL NAME: Eason Morgan
3. (b) If veteran, name war: World War I
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced
6. (b) Name of husband or wife: –
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: October 17, 1894 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
48	2	6	hr. ____ min.

9. Birthplace: Jacksonville, Illinois (City, town, or county) (State or foreign country) 1
10. Usual occupation: Produce Business -unemployed
11. Industry or business: "
MOTHER FATHER
12. Name: Stephen Morgan
13. Birthplace: – (City, town, or county) Illinois (State or foreign country) 1
14. Maiden name: Sarah Robinson
15. Birthplace: – (City, town, or county) Illinois (State or foreign country) 1
16. (a) Informant: Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address:
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-23-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Removed to St. Louis, Mo.
18. (a) Signature of funeral director: Claude Prichard, Undertaker
(b) Address: Excelsior Springs, Mo.
19. (a) 12-29-42 (Date received local registrar) Mrs Sadie Redmon (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: December day: 23 year: 1942 hour: 6:45 minute: A. M.
21. I hereby certify that I attended the deceased from March 19, 1942 to December 23, 1942 that I last saw him alive on December 23, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis of Larynx	unknown
Due to: Tuberculosis, pulmonary, chronic, far advanced, active	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy: No autopsy

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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? Means of injury:
23. Signature: FORREST G. BELL, M. D. (M. D. or other)
Address: Veterans Administration Excelsior Springs, Mo. Date signed: 12-23-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number .....
Date Filed 1-8-43

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, 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 this body is not embalmed, fact should be so stated above.