

S. No. 2
M-2-4
5-17-39
P-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14041

State File No.

FILED MAY 14 1945

Registrar's No. 14

Registration District No. 226

Primary Registration District No. 4337

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

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Madison
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby 102
(c) City or town Shelbina 2
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME Rosa Lee Morrison

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife: 6. (c) Age of husband or wife if alive: 17th years (Day) (Year)

7. Birth date of deceased: November 17th 1869
(Month) (Day) (Year)

8. AGE: Years 175 Months 5 Days 5 If less than one day hr. min.

9. Birthplace: Monroe Co Mo Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business:

12. Name Bert Chapman

13. Birthplace: Mo
(City, town, or county) (State or foreign country)

14. Maiden name: Elizabeth Campbell

15. Birthplace: Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Wm Thompson

(b) Address: Shelbina Mo

17. (a) Burial (b) Date thereof: 4/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of cremation: Spencer Chapel

18. (a) Signature of funeral director: Million & Barkelew

(b) Address: Shelbina Mo

19. (a) 5/1/45 (b) Oto Hedberg
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd
year 1945 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from April 15 1945, to April 22 1945;
that I last saw her alive on April 21 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia Duration 2 days
Due to: Cardiac insufficiency 1 mo
Due to: Cardio-vascular-renal disease years
Other conditions:

Major findings: 15/10
Of operations:
Of autopsy:

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: J.P. Gurnea DO. (M. D. or other)
Address: Madison Mo Date signed: 5/1/45

1126

MAY 10 1945

RECEIVED

District Health Officer No. 10

District File Number 5-45-766

Date Filed MAY 10 1945

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 *Henry A. Parkes*

Licensed Embalmer No. 3835

P. O. Address *Chelmsford 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.