V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr.R.A.Michael.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30588

FILED SEP 25 1945

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 695

39
2
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1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 906 East Chestnut /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 906 East Chestnut 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Walter Robert Morton
3. (b) If veteran, name war unk.
3. (c) Social Security No. 500-10-0010
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife unk.
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased March (Month) 25 (Day), 1884 (Year)

8. AGE: Years 61 Months 8 Days 6 If less than one day hr. min.

9. Birthplace unk. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Engineer at Court House
11. Industry or business
12. FATHER Name Frank Morton
13. FATHER Birthplace unk. (City, town, or county) Tenn. (State or foreign country)
14. MOTHER Maiden name Tennessee Shields
15. MOTHER Birthplace unk. (City, town, or county) Tenn. (State or foreign country)
16. (a) Informant Mrs. Edna Beard
(b) Address 1007 E. Chestnut, Sprd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn
18. (a) Signature of funeral director W. L. Dunn
(b) Address Springfield, Mo.
19. (a) 9-7-45 (Date received local registrar) (b) Mrs Hamby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1st. year 1945 hour 9 minute 15 A. M.
21. I hereby certify that I attended the deceased from Aug. 5, 1945, to Sept. 1, 1945, that I last saw him alive on Sept. 1, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration
Due to
Due to
Other conditions Cardiac Decompensation
(Include pregnancy within 3 months of death)
Major findings:
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 R. A. Michael M.D. (M. D. or other)
Address Springfield, Mo. Date signed 9-7-45

984 (Licensed Embalmer's Statement on Reverse Side)

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 Carl McCallum

Licensed Embalmer No. 28-91

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, fact should be so stated above.