

No. 2
-5-43
-17-39
X36671

Registration District No. **30819**

Primary Registration District No. **3537 4280**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County L Lawrence
(b) City or town Stotts City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Lifetime - 52 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County L Lawrence **55**
(c) City or town Stotts City, Mo. **0**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clarence Henry Morris

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Month) (Day) (Year)

7. Birth date of deceased May 10 1945
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 22 If less than one day hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Clarence F. Morris

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

14. Maiden name Olinda S. Beckmeier

15. Birthplace Stotts City, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Henry Beckmeier
(b) Address Stotts City, Mo.

17. (a) Burial (b) Date thereof July-14-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evangelical Cemetery

18. (a) Signature of funeral director H.P. Fossett
(b) Address Mt. Vernon, Mo.

19. (a) 9-5-45 (b) Chellona
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1945 hour 7 PM minute _____ M.

21. I hereby certify that I attended the deceased from May 10, 1945, to July 7, 1945
that I last saw him live on July 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital defective heart Duration all life

Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations _____
Of autopsy none

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. Hallock (M. D. or other) _____
Address Mt. Vernon, Mo. Date signed 8-11-45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 1045-1014

Date Filed OCT 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.....

By me

.....Registered Apprentice No.....

working under my personal supervision.

Signed *J. Max L. Trout*

Licensed Embalmer No. *4352*

P. O. Address *M. Werner, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34119
Nov
6

State File No.

Registrar's No.

Registration District No. 176

Primary Registration District No. 4280

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Stotts city
(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

3. (a) PRINT FULL NAME Clarence H. Morris
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 S

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

7. Birth date of deceased: May 10 1945
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Clarence F. Morris

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

14. Maiden name Aleida Beckemer

15. Birthplace Stotts city, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Beckemer

(b) Address Stotts city, Mo.

17. (a) Burial (b) Date thereof 7-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evangelical cemetery

18. (a) Signature of funeral director H.W. Fossett
(b) Address Mt Vernon, Mo.

19. (a) _____ (b) W.S. Bussing
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Stotts city
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1945 hour _____ minute _____ M.

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

Immediate cause of death congenital defective heart Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE IN INK—UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1872-2745-

There no postage whatever & may
be sent.

APP