

No. 2
12-45
17-39

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4988**
Registrar's No. **609**

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

FILED FEB 21 1947
Registration District No. **1002**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kennett City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
548 Main St 3
(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 **unknown**

3. (a) PRINT FULL NAME **Otto LeRoy Morningstar**

3. (b) If veteran, name war **NONE**

3. (c) Social Security **487-16-7491**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Agness Morningstar**

6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **Oct 11 1893**
(Month) (Day) (Year)

8. AGE: Years **53** Months **3** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **Gratis Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business _____

12. Name **Hasakah Ezeio**

13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Katharine Fought**

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

16. (a) Informant **Agness Morningstar**

(b) Address **1707 PROSPECT AVE**

17. (a) **Burial** (b) Date thereof **Feb. 17 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Evans Lawn**

18. (a) Signature of funeral director **Passarino Bros**

(b) Address **12 C.M.O.**

19. (a) **2-10-47** (b) **Thereldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson**

(c) City or town **Kennett City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1707 PROSPECT AVE**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **8**
year **1947** hour **8** minute **30 P.M.**

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

Immediate cause of death **Coronary Insufficiency**

Due to **arteriosclerosis**

Due to _____

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

Major findings: Of operations **950**

Of autopsy **no**
Arteriosclerosis

22. If death was due to external causes, fill in the following:

(c) 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) (e) Means of injury **3**

23. Signature **James Walker** (M. D. or other) _____

Address **1424 1/2th St** Date signed **2-10-47**

48
38
8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Francis Walton*
Licensed Embalmer No..... *2744*
P. O. Address..... *12 CMO*

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.