

Registration District No. 128 Primary Registration District No. 5466

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Rural Springfield - S. Campbell Hosp**
(c) Name of hospital or institution: **Ozark Osteo Hosp.**
(d) Length of stay: **10 Weeks**
In this community **10 Weeks**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Christian**
(c) City or town **Billings**
(d) Street No. _____
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME **Lester Irvin Morelock**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **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
7. Birth date of deceased **May 15 1934**

8. AGE: Years **13** Months **0** Days **2** If less than one day hr. _____ min. _____

9. Birthplace **Springfield, Missouri**

10. Usual occupation **Student**

11. Industry or business _____

12. Name **Earnest Morelock**
13. Birthplace **Laclede County, Missouri**
14. Maiden name **Nellie Slavens**
15. Birthplace **Arkansas**

16. (a) Informant **Earnest Morelock**
(b) Address **Billings, Mo.**

17. (a) **Burial** (b) Date thereof **5/18/47**
(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **H.H. Lohmeyer**
(b) Address **Springfield, Mo.**

19. (a) **5-18-47** (b) **W.E. Handley WED**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **17** year **1947** hour **1** minute **05a.** M.

21. I hereby certify that I attended the deceased from **March 9 1947** to **May 17 1947** that I last saw him alive on **May 16 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **General peritonitis**
Due to **ruptured appendix**

Other conditions _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____
23. Signature **William J. [unclear]**
Address **Springfield, Mo.** Date signed **5-17-47**

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

MOTHER FATHER

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.....

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.