

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

8745

State File No.

FILED APR 11 1955

BIRTH NO. _____ REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3039 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Lingo Twp. Co. 0610</u>	
c. LENGTH OF STAY (in this place) <u>45 Days</u>		d. STREET ADDRESS (If rural, give location) <u>City limits of New Cambria</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lulu</u> b. (Middle) <u>Morrow</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 16 1955</u>		
---	--	--	---	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 8 1870</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
-----------------	----------------------------	---	-------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>New Cambria, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	---	--	--

13a. FATHER'S NAME <u>Watkin C. Jones</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>	14. NAME OF HUSBAND OR WIFE <u>J. William Morrow</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. John Ben Jones, New Cambria</u>
---	------------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Colon c</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Metastasis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>153 X</u>
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from 1-30, 1955, to 3-16, 1955, that I last saw the deceased alive on 3-16, 1955, and that death occurred at 2-20 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John Ben Jones</u>	23b. ADDRESS <u>Marceline, Mo</u>	23c. DATE SIGNED <u>3-16-55</u>
--	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MARCH 18, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NEW CAMBRIA</u>	24d. LOCATION (City, town, or county) (State) <u>NEW CAMBRIA Mo</u>
---	---------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>3/17/55</u>	REGISTRAR'S SIGNATURE <u>M. J. Ridgway</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. J. Lillard New Cambria Mo</u>
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

581
0

AUG 2 1955

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 _____

H. J. Gilleland

Student Embalmer No. _____

working under my personal supervision.

Signed _____

H. J. Gilleland

Signed _____

Student Embalmer

Licensed Embalmer No. *4019*

P. O. Address *New Cambria 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.