

FILED MAY 1 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **12258**

|   |  |  |  |   |  |   |  |                                  |  |
|---|--|--|--|---|--|---|--|----------------------------------|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>10</b>   |  | PRIMARY REG. DIST. NO. <b>3002</b>  |  | Registrar's No. <b>76</b>   |  |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Audrain</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY <b>Audrain</b>  |  |   |  |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>Mexico</b>  |  | c. LENGTH OF STAY (in this place)  |  | c. CITY OR TOWN <b>Mexico</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Audrain County Hospital</b>  |  |  |  | e. STREET ADDRESS (If rural, give location) <b>614 West Liberty</b>   |  |   |  |                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>Lucy</b><br>b. (Middle) <b>Ella</b><br>c. (Last) <b>Morris</b>   |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>April 23 1956</b> |   |  |   |  |                                  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>   |  | 8. DATE OF BIRTH <b>Feb. 12 1883</b>  |  |                                  |  |
| 9. AGE (in years last birthday) <b>73</b>   |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 4 HRS. Hours _____ Min. _____  |  |   |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Wheeling, W. Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                                  |  |
| 13a. FATHER'S NAME <b>William Coates</b>  |  |  | 13b. MOTHER'S MAIDEN NAME <b>Martha Jane Postelwait</b>    |   |  | 14. NAME OF HUSBAND OR WIFE   |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Roy S. Leebrick Mexico, Mo.</b>   |  |   |  |                                  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.              |  |  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |  | INTERVAL BETWEEN ONSET AND 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)   |  |   |  |                                  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.  |  | 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 <b>9-9 1954</b> to <b>4-23 1956</b> that I last saw the deceased alive on <b>4-22 1956</b> and that death occurred at <b>11:00</b> m., from the causes and on the date stated above. |  |  |  |   |  |   |  |                                  |  |
| 23a. SIGNATURE (Degree or title) <b>M. D. Kellenbach</b>  |  |  |  | 23b. ADDRESS <b>Mexico, Mo</b>  |  | 23c. DATE SIGNED <b>April 25 1956</b>   |  |                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 24b. DATE <b>April 25 1956</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Centralia</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>Centralia, Missouri</b>  |  |                                  |  |
| DATE REC'D BY LOCAL REG. <b>April 25-1956</b>   |  | REGISTRAR'S SIGNATURE <b>Blanche Neely</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arnold Funeral Home Mexico, Mo.</b>   |  |   |  |                                  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 20 1958

**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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Leo Miller*

Licensed Embalmer No. *44*

P. O. Address *Med...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.