

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23767

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 198

1. PLACE OF DEATH a. COUNTY <u>Calloway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Calloway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Sublets</u> <u>014th</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Calloway Hosp</u> Length of stay in 1b <u>10 days</u>		d. STREET ADDRESS (If outside, give location) <u>R.D. 1.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clemona E. Morgan</u> First Middle Last		4. DATE OF DEATH <u>Aug 3 57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6-1884</u>
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Warsaw Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Newton Wheeler</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine King</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no., or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>N</u>		17. INFORMANT <u>Ms Alma Gothright</u> Address <u>Ka Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Myocardial</u> DUE TO (c) <u>Regeneration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Regeneration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1954</u> to <u>1957</u> and last saw her alive on <u>Aug 3 1957</u> Death occurred at <u>5:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John J. Brown MD</u>		22b. ADDRESS <u>Fulton Mo.</u>	
22c. DATE SIGNED <u>8-7-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Aug 4-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bell Cemetery</u>	
23d. LOCATION (City, town, or county) <u>New Springfield Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Edgar Davenport</u> ADDRESS <u>New Springfield</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 7-1957</u>	
25. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, Welfare, Public Service, 00-56, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Leroy Claypool*
Licensed Embalmer No. *44*

P. O. Address *Northbrook*

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.