

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009005

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1395

FILED APR 10 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Greene	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D. O. A. Menorah Med. Center		Length of stay in 1b 5 days		c. CITY OR TOWN Springfield		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS R. R. 10, Box. 465		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. SEX	
First Paul		Middle L.		Last Morgan		Month March Day 17 Year 1961	
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-13-30	
9. AGE (last birthday) 30		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) brickmas on		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (City and state or country) Missee Mills, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Samuel Franklin Morgan			
13b. MOTHER'S MAIDEN NAME Lillie Mae Clark				14. NAME OF HUSBAND OR WIFE Caroline Morgan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Korean		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Springfield, Mo. Mrs. Caroline Morgan R. 10, B. 465			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute circulatory failure							
DUE TO (b) cause undetermined							
DUE TO (c) no trace of barbiturates							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year					
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		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Geo. C. Kealnoyer, M.D.</i>				22b. ADDRESS 6627 Prospect K. C. Mo.		22c. DATE SIGNED 3-12-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 3-20-61		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Mo.	
24. FUNERAL DIRECTOR Weillert Funeral Home, K. C. Mo.				25. DATE RECD. BY LOCAL REG. 3-18-61		26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>	

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.

1967 MAY 11 1967

APR 18 1967

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. _____
P. O. Address _____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.