

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045992

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. ---- Registrar's No. 1495

STATE FILE NUMBER

FILED JAN 14 1963

VS 300
Rev. 4/59

15116
25110

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1290-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF M.H. Christ, M.D. MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twsp.</u>		Length of stay in 1b <u>56 Years</u>	c. CITY OR TOWN <u>Washington Twsp.</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>Lake Contrary</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lake Contrary</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maude Lillian Morrison</u>			4. DATE OF DEATH Month Day Year <u>December 30 1962</u>
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>2-23-1868</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	9. AGE (last birthday) <u>94</u> IF UNDER 1-YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME <u>J. R. Bowers</u>		11b. MOTHER'S MAIDEN NAME <u>Anna Ogle</u>	11. BIRTHPLACE (City and state or country) <u>Kittanning, Penn.</u>
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>Wm. Wesley Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Sister Mrs. L.F. Ingersol</u> Address <u>Lake Contrary</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>Cerebral Vascular Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>with Left hemiplegia</u>			
DUE TO (c) <u>Generalized Arteriosclerosis</u>			
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 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 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 <u>December 1962 Dec 30</u> and last saw her alive on <u>Dec 29, 1962</u>		Death occurred at <u>6:05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Martina Christ M.D.</u>		22b. ADDRESS <u>6106 King Hill Ave St Joseph</u>	22c. DATE SIGNED <u>1-4-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-2-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 8, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Woodell</u>

Permitted 1/2/63

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 Robert W. Hadley, Student Embalmer No. 662

working under my personal supervision.

Student Robert W. Hadley
Signature of Student Embalmer

Signed Raymond H. Hoover

Licensed Embalmer No. 5149

P. O. Address Alfred St 9

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.