

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0017306

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 336 Primary Registration District No. 6119 Registrar's No. 344 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 1 1967	
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Shannon</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Summersville ALLEY Twp.</u> Length of stay in 1b</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u></p> <p>c. CITY OR TOWN <u>Summersville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. NAME OF DECEASED</b> First <u>Melvin</u> Middle <u>R.</u> Last <u>Morrow</u></p>	
<p><b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>14</u> Year <u>1967</u></p>	
<p><b>5. SEX</b> <u>male</u></p>	<p><b>6. COLOR OR RACE</b> <u>white</u></p>
<p><b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>7/10/1895</u></p>
<p><b>9. AGE</b> (last birthday) <u>71</u></p>	<p><b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u></p>
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u></p>	<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Rector, Missouri</u></p>
<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Rector, Missouri</u></p>	<p><b>12. CITIZEN OF WHAT COUNTRY</b></p>
<p><b>13a. FATHER'S NAME</b> <u>Thomas B. Morrow</u></p>	<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Sarah Francis Riley</u></p>
<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>Bernice M. Morrow</u></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>yes W.W.#1</u></p>	<p><b>16. SOCIAL SECURITY NO.</b></p>
<p><b>17. INFORMANT</b> <u>Bernice Morrow, Rt. 3 Summersville</u></p>	<p>Address</p>
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Inanition and Debilitation</u></p> <p style="text-align: center;">DUE TO (b) <u>Cerebral Thrombosis - new</u></p> <p style="text-align: center;">DUE TO (c) <u>Adeno Carcinoma of Sigmoid Colon 1 1/2 yrs</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral &amp; General Metastasis</u></p>	
<p>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</p>	
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>
<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p><b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year</p>	
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/></p>	<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>	
<p><b>21. I attended the deceased from</b> <u>1949</u> to <u>1967</u> and last saw him alive on <u>April 13</u></p> <p>Death occurred at <u>8:50p.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p><b>22a. SIGNATURE</b> (Degree or title) <u>Dr. Radew Hampton Do Summersville</u></p>	<p><b>22b. ADDRESS</b> <u>Summersville, Missouri</u></p>
<p><b>22c. DATE SIGNED</b> <u>4/23/67</u></p>	
<p><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>	<p><b>23b. DATE</b> <u>4/16/1967</u></p>
<p><b>23c. NAME OF CEMETERY OR GREMATORY</b> <u>City Cemetery</u></p>	<p><b>23d. LOCATION</b> (City, town, or county) (State) <u>Summersville, Missouri</u></p>
<p><b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Duncan Funeral Home Mtn. View, Mo.</u></p>	<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>April 18, 1967</u></p>
<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Nichelle Paein</u></p>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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MAY 2 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 \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

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.