

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67-0030037
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 436

DO NOT WRITE ON THIS STUB

AMENDED

| | | | | | | | | | |
|---|--|--------|------|-------|------|----------|-----------|--|--|
| FILED SEP 1 1967 | | | | | | | | | |
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Cape Girardeau</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Home Jackson Mo.</u> Length of stay in 1b _____</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> | <p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u></p> <p>c. CITY OR TOWN <u>Jackson Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>310 S. Missouri</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> | | | | | | | | |
| <p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;"><u>Nora Dell Morton</u></p> | <p>4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1967</u></p> | | | | | | | | |
| <p>5. SEX <u>F</u></p> | <p>6. COLOR OR RACE <u>W.</u></p> | | | | | | | | |
| <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> | <p>8. DATE OF BIRTH <u>Oct. 24-1885</u></p> | | | | | | | | |
| <p>9. AGE (last birthday) <u>81</u></p> | <p>9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>9</u></td> <td><u>26</u></td> <td></td> <td></td> </tr> </table> | Months | Days | Hours | Min. | <u>9</u> | <u>26</u> | | |
| Months | Days | Hours | Min. | | | | | | |
| <u>9</u> | <u>26</u> | | | | | | | | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u></p> | <p>10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping House</u></p> | | | | | | | | |
| <p>11. BIRTHPLACE (City and state or country) <u>Jackson Mo.</u></p> | <p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p> | | | | | | | | |
| <p>13a. FATHER'S NAME <u>Frank Swan</u></p> | <p>13b. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u></p> | | | | | | | | |
| <p>14. NAME OF HUSBAND OR WIFE <u>Ruel Morton Dec.</u></p> | <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u></p> | | | | | | | | |
| <p>16. SOCIAL SECURITY NO. <u>499-26-6108</u></p> | <p>17. INFORMANT <u>Lester Morton Floriesent Mo.</u> Address _____</p> | | | | | | | | |
| <p>18. CAUSE OF DEATH (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>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u></p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p> | | | | | | | | | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p> | <p>20a. ACCIDENT SUICIDE, HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> | | | | | | | | |
| <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p> | | | | | | | | | |
| <p>20c. TIME OF INJURY Hour _____ Month, Day, Year _____</p> | | | | | | | | | |
| <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> | <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> | | | | | | | | |
| <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p> | | | | | | | | | |
| <p>21. I attended the deceased from <u>10-28-50</u> to <u>Aug 20, 1967</u> and last saw her <u>him</u> alive on _____</p> <p>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p> | | | | | | | | | |
| <p>22a. SIGNATURE (Degree or title) <u>J. N. Jager, M.D.</u></p> | <p>22b. ADDRESS <u>Jackson, Mo</u></p> | | | | | | | | |
| <p>22c. DATE SIGNED <u>Aug 27 1967</u></p> | | | | | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> | <p>23b. DATE <u>Aug. 23-1967</u></p> | | | | | | | | |
| <p>23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u></p> | <p>23d. LOCATION (City, town, or county) <u>4 mi. E. Jackson Mo.</u> (State) _____</p> | | | | | | | | |
| <p>24. FUNERAL DIRECTOR <u>Deneke-Laird Inc. Jackson Mo.</u></p> | <p>25. DATE RECD. BY LOCAL REG. <u>8-28-67</u></p> | | | | | | | | |
| <p>26. REGISTRAR'S SIGNATURE <u>Jimmie Kasten</u></p> | | | | | | | | | |

VS 300 Rev. 4/59
 0161
 2 0161
 3
 4 1
 5 2
 6
 7 0
 8 0
 9 4200
 10
 11
 12 90-0
 13 1-0

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STANDARD 71

912 2101

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 R O. Laird

Licensed Embalmer No. 4538

P. O. Address Jackson Mo.

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.