

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3593
Registrar's No. 2

Registration District No. 775 Primary Registration District No. 6070-A

1. PLACE OF DEATH: **FILED FEB 12 1940**
(a) County St. Francois
(b) City or town Bonne Terre Mo
(c) Name of hospital or institution: Bonne Terre Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROSA MAY MORRIS
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Charles & Morris 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased July 28 1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Bonne Terre Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name of father Samuel R. Dyrington

13. Birthplace St. Genevieve Co Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Margaret

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles & Morris

(b) Address Bonne Terre Mo

17. (a) Burial (b) Date thereof Jan. 7 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marvin Chapel

18. (a) Signature of funeral director Bentham & Co
(b) Address 313 Bentham & Bonne Terre

19. (a) Jan. 6 1940 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(If outside city or town limits write "RURAL")
(d) Street No. North B. Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 4
year 1939 Hour 2 minute 30 P. M.
21. I hereby certify that I attended the deceased from Nov. 17
_____, 1939 to Jan. 4, 1940
that I last saw her alive on Jan 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic poisoning Duration 2 weeks
Due to _____
Due to _____

Other conditions Menopausal psychosis 3 mos.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature Marvin J. New (M. D. _____) 1
Address Bonne Terre, Mo. Date signed 1-9-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

G. J. Claywell

Licensed Embalmer No. *3706*

P. O. Address *Peene Ave 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 this body is not embalmed, above space should be left blank.