

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Jackson
Township
or
Village
or
City Kansas City (NO. 523 Norton St. Ward)

Registration District No. 399 File No. 8772
Primary Registration District No. 1002 Registered No. 1044

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Arthur Morris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE w 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
6 DATE OF BIRTH Oct- 24 1941
(Month) (Day) (Year)
7 AGE 74 yrs. 4 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9 BIRTHPLACE
(City or town, State or foreign country) England

PARENTS
10 NAME OF FATHER Jno Morris
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Wales
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wales

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Betsy Moses Morris
(Address) 523 Norton

15 MAR 23 1915
Filed 191 W.S. Wheeler
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 22 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 28 1915 to March 22 1915, that I last saw him alive on March 22 1915 and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
180A
16.15
82A (Duration) yrs. mos. 1 ds.

CONTRIBUTORY Fracture of neck of femur
(Secondary) (Duration) yrs. mos. 23 ds.
(Signed) Emil Theilmann M. D.
Med 23 1915 (Address) 314 Altman Bld.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place 25 yrs. mos. ds. In the 25 State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Cleveland Ohio DATE OF BURIAL Mar 24 1915

20 UNDERTAKER Mrs. C. P. Forster ADDRESS 915 Brooklyn

28 = 3242 - 15

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or Village _____

or City _____

Registration District No. 399

File No. _____

Primer Registration District No. 1002

Registered No. 1044

City Kansas City MO. 523 Norton St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Arthur Morris

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M

COLOR OR RACE W

SINGLE M
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH Mar 22, 1915

(Month) (Day) (Year)

DATE OF BIRTH _____

(Month) (Day) (Year)

AGE _____

If LESS than 1 day, _____ hrs. _____ min. or _____ yrs. _____ mos. _____ ds.

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at 5:05 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) _____

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 3/23 1915 W.S. Wheeler REGISTRAR

Contributory Fracture of neck of spine

(SECONDARY)

Accidental cause by fall 12/5

(Signed) E. Schulman M. D.

3/23 1915 (Address) 314 Altman

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 1915

UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

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 OCCASION is very important.

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[Approved by U. S. Census and American Public Health
Association]

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