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

Do not use this space.

8317

File No. 1171

Registered No.

1. PLACE OF DEATH

County: Jackson — Registration District No.:

Township: Kaw — Primary Registration District No.:

City: K. C. Mo. (No. 3347 Olive St. St. Ward)

2. FULL NAME Elizabeth A. Morgan

(a) Residence. No. 3347 Olive St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	White	Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Hunt Morgan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-3-1833

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	3	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mass

PARENTS

10. NAME OF FATHER Thos. Leslie

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Scotland

12. MAIDEN NAME OF MOTHER A. B. Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Conn

14. INFORMANT George E. Morgan
(Address) 3347 Olive St

15. FILED 3/19, 1927 M. McCrone, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch-18-1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1926, to Mar. 18, 1927, that I last saw h. alive on Mar. 7, 1927, and that death occurred, on the date stated above, at 9:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia - resulting from debility of old age

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) Senile

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Usual appearance

(Signed) Lucille E. Quesenberry, M. D.

3/19, 1927 (Address) 556 Linwood Blvd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Washington	Mch. 18 1927
20. UNDERTAKER	**ADDRESS**
Mrs. C. L. Foster	K. C. Mo.

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.

WHITE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

325 Schubert