

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

Do not use this space.

8433

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Precinct Registration District No. 1007
 City Kansas City, Mo. Old City Hosp File No. _____
 Registered No. 1007 St. 1200 Ward _____
 2. FULL NAME Lee Morton
 (a) Residence, No. 724 Lawford St. Ward. _____
 (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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE negro 5. SINGLE/MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1882
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 yrs - - -
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Common Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Old City Hospital
 (Address) K. C. Mo

15. FILED 2/28 1927 M. M. Brown
dech REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5 - 1927
 17. I HEREBY CERTIFY, That I attended deceased from February 2 - 1927 to March 5 - 1927 that I last saw him alive on March 4 - 1927, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Pulmonary Tuberculosis
Chronic Myocarditis
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clin & Laboratory
 (Signed) H. M. Smith M. D.
3-4-1927 (Address) Old City Hosp - K.C. Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Lawn Cemetery DATE OF BURIAL Mar 28 1927

20. UNDERTAKER West Applegate & Sons ADDRESS 600 E. 19th

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

JUN 20 1956