MAR 27 1930

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

Do not use this space.

5315

1. PLACE OF DEATH
County Jackson — Registration District No. 400 — File No.
Township Prairie — Primary Registration District No. 5592 B — Registered No. 84
City (No. St. Ward)

2. FULL NAME Henry ~~Morse~~ Morris
(a) Residence. No. Jackson County Home St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
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)
Male	white	Single Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-12-1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	77	10	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer unknown

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

PARENTS
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 J. W. Hostetter
(Address) Jackson Co Home

15. FILED 2-19-30 W. S. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby 17 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to Feb - 17, 1930 that I last saw him alive on Feb 17, 1930, and that death occurred, on the date stated above, at 3 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
?
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) General inanition
(duration) yrs. 1 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? Clinical
(Signed) J. W. Greene, M. D.
2/19, 1930 (Address) Independence

*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
Maple Hill	Feb 19 1930
20. UNDERTAKER	ADDRESS
Kettleman	City

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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