

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

Do not use this space.

16136

1. PLACE OF DEATH

County Jackson
Township Hann
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. 2300 Holligs)

File No. _____
Registered No. 20044
St. _____ Ward _____

2. FULL NAME

Harold E. Morgan
(a) Residence. No. St. Anthony's Home St. 11 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-24-30

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>1</u>	<u>14</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) K. C. Kans
(STATE OR COUNTRY)

PARENTS

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

14. INFORMANT Sister M. Joseph
(Address) St. Anthony's Home 234 Collg

15. FILED 5/12/30 W. M. Crowl
REGISTRAR Ans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1930

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 9, 1930 that I last saw harold alive on May 9, 1930, and that death occurred, on the date stated above, at 1:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho pneumonia
Primary
107A (duration) yrs. _____ mos. 7 ds.
CONTRIBUTORY (SECONDARY) 1000W (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF None
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Alfred Bailau, M. D.
5/9, 1930 (Address) St. Anthony Home

*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 St Marys Cemetery DATE OF BURIAL May 12 1930
20. UNDERTAKER John W. Wagner ADDRESS 1409 Grand Ave

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.

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WHILE DEATH IS BEING INVESTIGATED THIS IS A PERMANENT RECORD

