16-267

DEC 26 1935

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

Do not use this space.

36276

File No.
Registered No.

1. PLACE OF DEATH Jackson.
County
Registration District No.
Township Kaw
Primary Registration District No.
City Kansas City Mo., (No. General Hospital. St. Ward)

2. FULL NAME R. A Morris

(a) Residence, No. Unknown 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: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Unknown

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

7. AGE: Years App 50; Months; Days; If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Not known
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Floral Hill DATE 11/26/35 19

19. UNDERTAKER (ADDRESS) 3146 Main St

20. FILED 11-26 1935 M. M. Crowe, Asst Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 19th 35, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw him alive on 6 25 P.M., 19.... Death is said to have occurred on the date stated above, at 6.25P m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Pneumococcic Meningitis | |
| | |
| | |
| | |
| | |
| Other contributory causes of importance: | |
| | |
| | |
| | |

Name of operation Date of
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Russell W Fen, M. D.
(Address) KC 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.