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.

100M-3-28-35

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

JAN 23 1936

Do not use this space.
39509
4563

1. PLACE OF DEATH
County Jackson Registration District No. 3 File No.
Township Kaw Primary Registration District No. Registered No.
City Kansas City (No. Trinity Lutheran Hospital St. Ward)

2. FULL NAME Robert Morris
(a) Residence, No. 3909 Michigan St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 20 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): WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF ~~(OR) WIFE OF~~ MRS. MARGARET E. MORRIS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC-16-1841

7. AGE: YEARS 93 | MONTHS 11 | DAYS 20 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. RETIRED
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 COUNTY) FLINT COUNTY WALES

FATHER
13. NAME ROBERT MORRIS
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) WALES

MOTHER
15. MAIDEN NAME CATHERINE WILLIAMS
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) WALES

17. INFORMANT MRS. ELIZABETH OLSON
(ADDRESS) 3909 MICHIGAN AVE.

18. BURIAL, CREMATION, OR REMOVAL
PLACE SCRANTON, KANSAS DATE DEC-8 1935

19. UNDERTAKER D.W. NEWCOMERS SONS
(ADDRESS) KANSAS CITY, MISSOURI

20. FILED 12-7 1935 M M Crowe
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 6 1935

22. I HEREBY CERTIFY, That I attended deceased from Dec 6 1935, to Dec 6 1935
I last saw him alive on Dec, 6 1935. Death is said to have occurred on the date stated above, at 9:40 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Terminal Bronchio-pneumonia	12/4/35
Other contributory causes of importance:	
Chronic Myocarditis	—
Anthracosis	—
Generalized arteriosclerosis	—

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) J. Barrick Wilson, M. D.
(Address) Trinity Hospital