

DEC 0 MAY 10 1938

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

13788
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Flaw Primary Registration District No. 1002 Registered No. 1542

(c) City K. C. Mo. (d) Street No. General Hospital # 2 St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Infant Morgan

(a) Residence, No. 2423 K. C. Mo. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Colored

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) 4-7-1939

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

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. Not Employed

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) Mo.

FATHER

13. NAME Lewis Morgan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME Mary Louise Parker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Higginsville Mo.

17. INFORMANT (ADDRESS) Record Clerk General Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds Cemetery DATE 4-11-39

19. FUNERAL DIRECTOR (ADDRESS) West Appleton Jones Inc 1905 Vine Street

20. FILED Apr 11 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-7-1939

22. I HEREBY CERTIFY, That I attended deceased from 4-7-1939, to 4-7-1939. I last saw him alive on 4-7-1939. Death is said to have occurred on the date stated above, at 2:30 p.m. The principal cause of death and related causes of importance were as follows: Cerebral Hemorrhage Date of onset 1608

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? no.

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. O. Brown, M. D. (Address) General Hospital # 2

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.

STATEMENT BY LICENSED EMBALMER

I, E. H. West, Licensed Embalmer No. 2710

hereby certify that the body recorded on the reverse side of this certificate was embalmed by [Signature]

L. E. E. H. West

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)