

REC'D AUG 7 1939

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

24563
Do not use this space
3776

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Ida Primary Registration District No. 100P Registered No. 3776
 (c) City Mo. Mo. (d) Street No. Trinity Lutheran Hopt 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

(a) Residence, No. 404 E 43 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maudie Morrow
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1/29/1880
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
59 5 11
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lawyer
 9. Industry or business in which work was done, as law mill, bank, etc. Lawyer
 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) Virginia
 13. NAME Wm H. Morrow
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.
 15. MAIDEN NAME Julia Wilson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) Mrs Maudie Morrow 404 E 43
 18. BURIAL, CREMATION, OR REMOVAL PLACE Slater Mo DATE 7/10, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stine McClure Kansas City Mo
 20. FILED July 10 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 10, 1939
 22. I HEREBY CERTIFY That I attended deceased from Dec-20, 1938, to July 10, 1939
 I last saw him alive on July 9, 1939. Death is said to have occurred on the date stated above, at 5:30 A.M.
 The principal cause of death and related causes of importance were as follows:

Arteriosclerotic heart disease
Hypertensive cardiomegaly
disease
95%
 Date of onset Dec 1938
13 years
 Other contributory causes of importance:
Prostatic Hypertrophy
1 year

Name of operation..... Date of.....
 What test confirmed diagnosis clinical. 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? no
 If so, specify.....
 (Signed) W. H. Brown, M. D.
 (Address) Parrot Night Bldg - Kansas City, Mo

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.

Dr. [illegible]

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed..... *[Signature]*

Licensed Embalmer No. *1413*

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.