

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not to hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community about 6 (six) years (Specify whether years, months or days)

NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 420 W. Gregory Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26 - 1939
year 1939 hour 12:00 noon minute _____ M.

21. I hereby certify that I attended the deceased from November, 1936, to Oct 26, 1939, that I last saw her alive on Oct 26, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
Semibility Duration _____

Due to Semibility
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (Country) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature A. M. Ziegler (M. D. or other) _____
Address 501 Plaza Shelter Bldg Date signed 10/26/39

3. (a) PRINT FULL NAME MRS CATHERINE MORRISON

3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife ROBERT J. MORRISON 6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased October 26 1854
(Month) (Day) (Year)

8. AGE: Years 85 Months 0 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace Pottsville Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Tom Casey

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Anna O'Reilly

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs J. B. Huckle

(b) Address 420 West Gregory

17. (a) Removal (b) Date thereat 10/26/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo

18. (a) Signature of funeral director W. J. McConis

(b) Address 1401 Brush Creek Blvd

19. (a) 10/26/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

By: C. M. Seigler
Holographic Bldg.
D-5 P.M.

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D. C. Mo.

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.