

Registration District No. 399

Primary Registration District No. 1002

JAN 13 1940

1. PLACE OF DEATH:

(a) County Jackson City
 (b) City or town Jackson City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Mary's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution one day
 (Specify whether
 In this community Don't know
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Jackson City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1310 49th Street Blvd
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. Don't know years.

3. (a) PRINT FULL NAME Morris Ross 200

3. (b) If veteran, name war WWI 3. (c) Social Security No.

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

6. (b) Name of husband or wife 6. (c) Age of husband or wife if years

7. Birth date of deceased Don't know
 (Month) (Day) (Year)

8. AGE: Years about 60 Months Days If less than one day hr. min.

9. Birthplace Don't know
 (City, town, or county) (State or foreign country)

10. Usual occupation Produce Dealer

11. Industry or business

12. Name Don't know

13. Birthplace Don't know
 (City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

(b) Address

17. (a) Burial (b) Date thereof 12/29/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelfield

18. (a) Signature of funeral director Carroll D. Darden

(b) Address 3824 Frost

19. (a) Dec 29, 1939 (b)
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 Day 23 Year 39
 year hour minute M.

21. I hereby certify that I attended the deceased from 4:30 P.
 , 19 , to , 19 ;
 I last saw alive on , 19 ;
 and that death occurred on the date and hour stated above.

Immediate cause of death Duration

Atelectasis of left lung
 Due to

Bronchial asthma
 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) (County) (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) Nature of injury

23. Signature (M.D. or other)

Address Date signed

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.

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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.....

E. P. Casey

Licensed Embalmer No. *1972*

P. O. Address *3024 Front*

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.