

No. 2  
-11-10-39  
5-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41308

State File No.

FILED JAN 8 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4701

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town J.C. Mo  
(c) Name of hospital or institution: St Marys Hospital  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert D. Morrison

8. (b) If veteran, name war L 8. (c) Social Security No.       

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased Aug 21 1858  
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 14 If less than one day hr.        min.       

9. Birthplace Milan, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Printer

11. Industry or business New Paper

12. Name R. D. Morrison

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

14. Maiden name Sarah Sawyer

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

16. (a) Informant J. B. Brown

(b) Address 4939 Collage

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Cem. Milan

18. (a) Signature of funeral director W. F. M. M. Brown

(b) Address 2315 1/2  
19. (a) 12-10-40 (Date received local registrar) (b) W. F. M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town J.C. Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4939 Collage  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 82 years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5 year 1940 hour        minute        M.

21. I hereby certify that I attended the deceased from Nov 25 1940 to Dec 6 1940 that I last saw him alive on 12-6 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Embolicus of left femoral artery  
Due to arteriosclerosis of aorta  
Other conditions: Langrene typh  
(Include pregnancy within 3 months death)

Major findings: 992  
Of operations         
Of autopsy as above

Duration         
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) Means of injury         
23. Signature W. F. M. M. Brown (M. D. or other)         
Address 1420 Prog Bldg Date signed 12-6-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Licensed Embalmer No. 2560

P. O. Address 2315 Linnwood

**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.**