

Registration District No. 399 Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution:  
2545 Benton Blvd. 1st Floor North  
(d) Length of stay: In hospital or institution 30 Years  
In this community 30 Years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 2545 Benton Blvd. 1st Floor N.  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Mrs. Edith McAllister Morrow

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mr. Edwin A. Morrow 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased June 16 19

8. AGE: Years 10 Months 0 Days 0 If less than one day hr. min.

9. Birthplace Fayetteville North Carolina

10. Usual occupation Housewife

11. Industry or business -----

12. Name Richard Burkett

13. Birthplace Scotland

14. Maiden name Martha

15. Birthplace England

16. (a) Informant Mrs. Jacqueline

(b) Address 2545 Benton Blvd

17. (a) Burial (b) Date thereof Apr. 17, 1941

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director W. H. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) 4/17/41 (b) M. M. Morrow

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th year 1941 hour 11 minute 20 A. M.

21. I hereby certify that I attended the deceased from 11-6-38 to 4-16 that I last saw him alive on 4-15 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis, chronic interstitial nephritis, myocarditis  
Due to General arteriosclerosis

Other conditions 121  
(Include pregnancy within 3 months of death)

Major findings: Of operations 121

Of autopsy 121

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 0

23. Signature John P. Lowrey (M. D. or other) -----  
Address Lathrop Blvd. Date signed 4-17-41

Duration  
Underline the cause to which death should be charged statistically.

10:30-5  
has done  
AR-2

**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 Emile M. Calhoun  
Licensed Embalmer No. 3506  
P. O. Address KC 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, fact should be so stated above.**

Registration District No. 399

Primary Registration District No. 1002.1

Registrar's No. 1387

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) Edith McAllister  
FULL NAME  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Apr day 16  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased June 16 185  
(Month) (Day) (Year)

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 9 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 83 Months 10 Days 01 If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) 4/17/41 (b) M M Brown  
(Date received local registrar) (Registrar's signature)

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 F. Lawrence (M. D. or other) \_\_\_\_\_  
Address Katharp 34 Date signed \_\_\_\_\_

SUPPLEMENTAL

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

MOTHER FATHER

