

6. 2  
10-39  
7-39  
DC2149Z

RECEIVED SEP 12 1941

State File No. \_\_\_\_\_

Registration District No. 379

Primary Registration District No. 1002

Registrar's No. 3249

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: St. Marys  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hours  
(Specify whether years, months or days) No

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County J. Johnson  
(c) City or town Spring Hill (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 Mis. East 3 Mis. No. Spring Hill  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 2 years

3. (a) PRINT FULL NAME Florence E. Morrison

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

4. Sex Fe 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Wayne Morrison  
6. (c) Age of husband or wife if alive 36 years  
7. Birth date of deceased October 19 1905  
(Month) (Day) (Year)

8. AGE: Years 35 Months 10 Days 10  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Spring Hill Kans  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William E. Fisdale  
13. Birthplace Unknown Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Alma Smith  
15. Birthplace Unknown Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Wayne Morrison

(b) Address Spring Hill

17. (a) Removed (b) Date thereof 8-27-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spring Hill, Kans

18. (a) Signature of funeral director Placid A. Wilcox  
(b) Address Spring Hill, Kans

19. (a) 8/29/41 (b) J. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29  
year 41 hour 112 minute 15 P. M.

21. I hereby certify that I attended the deceased from 8-28-41  
\_\_\_\_\_, 19\_\_\_\_, to 8-29, 1941  
that I last saw her alive on 8-29, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia - (culture not completed)  
Due to Abortion (spontaneous)  
Due to Pregnancy  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration 48 hr.  
8-24-41  
2 mo.

Major findings: Of operations none  
Of autopsy Refused 1406

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 A. R. Becker (M. D. or other) D  
Address 329 N. 2nd Date signed 8-29-41

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

36  
S. 10  
1940 - 18 - 29  
1908 - 10 - 19

36

**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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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