

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nice Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 yrs. (Specify whether
In this community 10 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2691 Forest (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Margaret ANN 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 Single

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

7. Birth date of deceased Jan 2 1953 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 3 5 hr. min.

9. Birthplace Clay Co Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Rooming House

11. Industry or business

12. Name Josiah Morrow
13. Birthplace South Carolina (City, town, or county) (State or foreign country)
14. Maiden name Dean Melbane
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mabel Morrow
(b) Address Lawson Mo
17. (a) Buried (b) Date thereof April 9 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Lawson Mo.

18. (a) Signature of funeral director Morrow Funeral Home
(b) Address Lawson Mo.

19. (a) 4-8-43 (b) M. M. Browne (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1943 hour 11.50 minute 0 M.

21. I hereby certify that I attended the deceased from May 1, 1942, to April 7, 1943, that I last saw him alive on April 6, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Paraplegia Duration 1 hr.

Due to Hypertension

Due to Chronic nephritis

Other conditions Old age 131B (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) (c) Means of injury.....

23. Signature G. W. Stovell (M.D. or other) DA
Address 241 W. Kelly Bldg Date signed 4-8-43

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

MOTHER FATHER

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 RR Mitchell

Licensed Embalmer No. 646

P. O. Address Independence, 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.