

FILED JUL 8 1943 149

Registration District No. \_\_\_\_\_

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  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 weeks 1 day  
In this community 5 weeks 1 day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Dickinson  
(c) City or town Abilene  
(If outside city or town limits, write "RURAL")  
(d) Street No. 914 N. Buckeye  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country I

3. (a) PRINT FULL NAME William Scott Morrison

(b) If veteran, name war World War #1 (c) Social Security No. 510-03-3523

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bessie Scott 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased July 13, 1893  
(Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Everett Washington  
(City, town, or county) (State or foreign country)

10. Usual occupation President Utility Co.

11. Industry or business Central Kansas Power & Light

12. Name William Morrison

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

14. Maiden name Margaret Scott

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

16. (a) Informant Mrs. W.S. Morrison  
(b) Address 914 N. Buckeye, Abilene

17. (a) Removal (b) Date thereof 6/21/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Abilene Kansas

18. (a) Signature of funeral director Geo. H. Long

(b) Address Kansas City, Kansas

19. (a) 6-21-43 (b) Dep. N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21  
year 1943 hour \_\_\_\_\_ minute 12:22 A.M.

21. I hereby certify that I attended the deceased from April 12, 1943 to June 21, 1943  
that I last saw him alive on June 21, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchiogenic carcinoma  
2. Metastatic carcinoma  
3. Secondary polythemia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy as above

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: Gerald B. Peery (M. D. or other) \_\_\_\_\_  
Address: Trinity Hospital Date signed: 6-21-43

AUG 28 1944

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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..... *Chas H. Rider* .....

Licensed Embalmer No. *3404* .....

P. O. Address..... *112 Kane* .....

**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.**