S. No. 2
M—2-43
5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. F 30861

FILED SEP 21 1949

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3777

1. PLACE OF DEATH:
(a) County: Jackson City,
(b) City or town: Kansas City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 821 West 59th Street, /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: no.
In this community: since 1898 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson, 48
(c) City or town: Kansas City, 2
(If outside city or town limits, write "RURAL") 6
(d) Street No.: 821 West 59th Street,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country: x

3. (a) PRINT FULL NAME: Robert Torrance Morrison,
3. (b) If veteran, name war: no.
3. (c) Social Security No.: no.
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed,
6. (b) Name of husband or wife: Laura Morrison
6. (c) Age of husband or wife if alive: dec. years
7. Birth date of deceased: October (Month) 26 (Day) 1856 (Year)

8. AGE: Years 86 Months 10 Days 4 If less than one day: hr. min.

9. Birthplace: Wisconsin, / (City, town, or county) (State or foreign country)
10. Usual occupation: Grain Merchange
11. Industry or business: Grain retired
MOTHER FATHER
12. Name: Henry J. Morrison,
13. Birthplace: Ohio, / (City, town, or county) (State or foreign country)
14. Maiden name: Sallie Ann Fox,
15. Birthplace: Unknown, ? (City, town, or county) (State or foreign country)
16. (a) Informant: S. Boone Gregg,
(b) Address: 5840 State Line, Kansas City, Kas
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-2-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Chapman, Kansas,
18. (a) Signature of funeral director: Stine & McClure,
(b) Address: 3235 Gillham Plaza, K. C., Mo.
19. (a) 9-1-43 (Date received local registrar) (b) T. E. Brown Dep (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 30 year: 1943 hour: 4 minute: 30 P M.
21. I hereby certify that I attended the deceased from Aug 13, 1943, to Aug 30, 1943, that I last saw him alive on Aug 30th, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Senile Cerebral Soften	14 days
with Thrombosis	
Due to: Paralysis of Oesophagus	2 days
Due to: Arteriosclerosis	years
Other conditions (Include pregnancy within 3 months of death): Senile Psychosis	
Cardiac Insufficiency	

Major findings:
Of operations: No
Of autopsy: No

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Theodore Anderson (M. D. or other)
Address: 723 W 45th Date signed: Aug 31, 43

(Licensed Embalmer's Statement on Reverse Side)

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. 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.