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3-13
7-39
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FILED JUN 29 1944
Registration District No. 149

Primary Registration District No. 1002

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:
General Hospital #2
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution **3 mos. 0**
7 months (Specify whether years, months or days)
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... **Missouri** (b) County... **Jackson** **48**
(c) City or town... **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No... **1312 Woodland**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country... **0**

3. (a) PRINT FULL NAME **Nettie Morris**

3. (b) If veteran, name war... **no** 3. (c) Social Security No... **none**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife... **Cpl. Shelby L. Morris** 6. (c) Age of husband or wife if alive... **21** years
7. Birth date of deceased **September 29 1925**
(Month) (Day) (Year)

8. AGE: Years **18** Months **8** Days **14** If less than one day hr. min.

9. Birthplace **Enid Okla.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Janitress**

11. Industry or business

MOTHER FATHER { 12. Name **Bethel Cole**
13. Birthplace **Meridian Miss.**
(City, town, or county) (State or foreign country)
14. Maiden name **Birdie Craig**
15. Birthplace **Muskogee, Oklahoma**
(City, town, or county) (State or foreign country)

16. (a) Informant **Birdie Cole**
(b) Address **1312 Woodland, K.C. Mo.**

17. (a) **Removal** (b) Date thereof **June 19 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Enid Okla.**

18. (a) Signature of funeral director **S. Sterling Kelly**

(b) Address **1212 Vine KCMO**

19. (a) **6-19-44** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **13**
year **44** hour **11:30 P** M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h... **Ann** alive _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation resulting from the rupture of the lower and feeding bronchopneumonia**
Duration
Asphyxiated in elevator shaft

Other conditions (Include pregnancy within 3 months of death)
(Not a fall)
Major findings:
Of operations _____
Of autopsy **See 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) **Accident 123**
(b) Date of occurrence **6/13/44**
(c) Where did injury occur? **1021 1/2 Grand Ave**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

(Specify type of place) (e) Means of injury

23. Signature **D. E. Brown** 3 (M. D. or other) **6/16/44**
Address _____ Date signed _____

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

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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

E. Steinhilber

Licensed Embalmer No.

3178

P.O. Address

1212 Pine

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2582

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Gen Hosp #2
(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) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Nettie Morria

3. (b) If veteran, name war..... 3. (c) Social Security No. 491-24-9186

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) 6-19-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 13 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.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

Duration

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

20769