

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 22 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3611

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:  
Willows Hospital-2929 Main St 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 minutes  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4  
(c) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2929 Main St  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Philip Morris

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

4. Sex male 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 Sept 3 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
-- -- -- -- hr. 20 min.

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

10. Usual occupation none

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Marjorie Morris

15. Birthplace Martinsville West Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant A.U. Dysart R.N.

(b) Address 2929 Main St

17. (a) Burial (b) Date thereof 9th 5th 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director Sylar Funeral Home

(b) Address 1800 Linwood

19. (a) 9-6-44 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 3 day 1944  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 7 P. M.

21. I hereby certify that I attended the deceased from Sept 3  
1944 to Sept 3 1944

that I last saw him alive on Sept 3 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation  
Toxemia of mother

Due to Toxemia of mother

Due to \_\_\_\_\_

Other conditions 161a  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy none

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 H. L. Dwyer (M. D. or other) \_\_\_\_\_

Address 315 Alameda Rd Date signed 9-3-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>not</sup> ~~was~~ embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Chas. Wilks

Licensed Embalmer No. 2644

P. O. Address 1900 Firwood

**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.**