. S. No. 2
M—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 22 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30234
Registrar's No. 3612

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: Childrens' Mercy Hospital, K.C. Mo (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2H 20 Min. 0 (Specify whether years, months or days)
In this community 2 Hrs. 20 Min

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Moniteau 68 0
(c) City or town California, Mo 0 (If outside city or town limits, write "RURAL")
(d) Street No. Rte #4 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Thomas Byron Morris
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex 0 Male
5. Color or race w
6. (a) Single, widowed, married, divorced 0 single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 26 (Day) 1943 (Year)

8. AGE: Years 1 Months 6 Days 20 9 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Jacob Morris 4
13. Birthplace Bellington (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name Lillian Hays
15. Birthplace Fortuna (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant mother
(b) Address California, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 (Month) 6 (Day) 44 (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director Boulin F. Home
(b) Address California, Mo.
19. (a) 9-6-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th. year 1944 hour 6 minute 20 P.M.
21. I hereby certify that I attended the deceased from 9-5, 1944 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Post Mortem
Due to 1. Leukemia c̄ marked secondary anemia (Lymphatic)
Due to 2. Hydropericardium
Other conditions (Include pregnancy within 3 months of death) 3 Subpericardial
Major findings: Of operations petechiae 4 Subcapsular
Of autopsy kidney petechiae

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J H Laskin M.D. (M.D. or other)
Address Mercy Date signed 9-6-44

(Licensed Embalmer's Statement on Reverse Side)

No. 4521

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 me, Registered Apprentice No. ....., working under my personal supervision.

Signed Earl R. Boulin

Licensed Embalmer No. 2126

P. O. Address Calisonia, Me

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.