

S. No. 2
FORM-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10279
State File No. 5011
Registrar's No.

FILED DEC 22 1944
Registration District No. 199

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether)

In this community 59 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town K.C.
(If outside city or town limits, write "RURAL")

(d) Street No. 614 Cambridge
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Susie Morrison

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Fem 5. Color or race Wh 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife John Morrison 6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased 5/27/1876
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 12 If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business none

12. Name Henry Bledsoe

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

14. Maiden name: No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Bertha Morrow

(b) Address 614 Cambridge

17. (a) Elmwood Cem. (b) Date thereof 12/11/44
(Burial, cremation or other) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director John P. Shell

(b) Address Kansas City, Mo.

19. (a) 12/11/44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9
year 1944 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from
Dec. 4 1944 to Dec. 9 1944
that I last saw her alive on Dec. 9 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompen-
sation

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death) 95C

Major findings:
Of operations.....

Of autopsy None

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) (c) Means of injury.....

23. Signature T. E. Brown (M. D. or other) 12-9-44
Address Med. Dir. Gen'l Hosp. Date signed

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 John P. Sheel
Licensed Embalmer No. 3625
P. O. Address. K B Md

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.