

FILED JAN 26 1945
Registration District No. 799

Primary Registration District No. 1002

Registrar's No. _____

160

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 3320 Gillham Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX (Specify whether
In this community 32 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri (a) State (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3320 Gillham Road
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM A. MORRISON

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Minna L. Morrison 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased November 21 1885
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Operator

11. Industry or business No Record

MOTHER FATHER

12. Name _____

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

14. Maiden name No Record

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

16. (a) Informant Mrs. Minna L. Morrison

(b) Address 3320 Gillham Road

17. (a) Burial (b) Date thereof Jan 12-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 1-11-45 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9th
1945 year hour 12: minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 9 to Jan 15
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Chronic nephroses
Due to arteriosclerosis

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

Major findings: Of operations None 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 J. V. Hill (M. D. or other) _____
Address 211 Professional Bldg Date Jan 15 1945

Duration 1 hr
Years 1
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Original
VI - 4238

SEP 4 1945

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address Kansas City, 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.