

S. No. 2
OM-5-43
ev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED OCT 16 1946 STANDARD CERTIFICATE OF DEATH

State File No. **33690**
4163
Registrar's No.

Registration District No. **149** 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:
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 years, months or days)
 In this community 32 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1213 Wabash
(If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME: William R. Morris
 3. (b) If veteran, name war no
 3. (c) Social Security No. 486-01-9255

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct. day 1
 year 1946 hour 12 minute 10 A.M.

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife William Morris
 6. (c) Age of husband or wife if alive unk years
 7. Birth date of deceased Aug 28 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 25 1946 to Oct. 1 1946,
 that I last saw him alive on Oct. 1 1946,
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>1</u>	<u>3</u>	hr. min.

Immediate cause of death Pulmonary thrombosis
 Duration _____

9. Birthplace Okla
(City, town, or county) (State or foreign country)
 10. Usual occupation Cook

Due to _____
 Due to _____
 Other conditions 111a
(Include pregnancy within 3 months of death)

MOTHER FATHER
 11. Industry or business _____
 12. Name Morris
 13. Birthplace No Record
(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)

Major findings:
 Of operations _____
See above
 Of autopsy _____

16. (a) Informant Lillian Morris
 (b) Address 1213 Wabash
 17. (a) Burial (b) Date thereof Oct-2-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Washington
 18. (a) Signature of funeral director Am. C. L. Foster
 (b) Address 918 Broadway
 19. (a) 10-2-46 (b) St. Rallding Holmes
(Date received local registrar) (Registrar's signature)

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 0
 23. Signature Brandon Thell (M. D. or other)
 Address Med. Dir. Gen'l Hosp. Date signed 10-1-46

David [unclear]

OCT 17 1946

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..... *Orland Minor*

Licensed Embalmer No. *3414*

P. O. Address *918 Brooklyn*

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.