

Registration District No. 73

Primary Registration District No. 5290

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Kearney Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

(c) City or town Kearney Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME RUSCO ORENDAW MORRISON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 24, year 1947, hour 8:00 minute 0 P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Norzi Lee 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 18 1898  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_ 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>3</u>	hr. _____ min. _____

Immediate cause of death Suicide  
12 gauge single shot  
gun

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

10. Usual occupation Farmer

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

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

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

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

12. Name William B Morrison

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

14. Maiden name Facy B. Perdue

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

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Leburn Morrison

(b) Address Excelsior Springs Mo

17. (a) Burial (b) Date thereof 2/24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview in Kearney

18. (a) Signature of funeral director Harold Jay

(b) Address Kearney Mo

19. (a) Feb 24, 1947 (b) Morrison  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence 2-24-1947

(c) Where did injury occur? 2 mi west Kearney, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home on farm

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 3

23. Signature RW Pracher (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Mo Date signed 2-22-47

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

to

MOTHER FATHER

64

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 3-27-47

APR 29 1947

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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 Donald Fry

Licensed Embalmer No. 1677

P. O. Address Warner 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.