

7. S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

9285

FILED APR 14 1947

State File No.

1551

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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 16 days
(Specify whether
 In this community 35 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 1406 Prospect 8
(If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
 year 1947 hour 2 minute 25 A.M.

21. I hereby certify that I attended the deceased from
March 16 1947 to April 2 1947
 that I last saw him alive on April 2 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____

Due to _____

Due to _____

Other conditions Fr. of left hip
(Include pregnancy within 3 months of death)

Major findings: 1860
 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) Accident 123
 (b) Date of occurrence 3-16-47
 (c) Where did injury occur? K. C. Jackson, Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place) (e) Means of injury Fall 0

3. (a) PRINT FULL NAME WILLIAM ROBERT MORRISON, SR.

3. (b) If veteran, name war No 3. (c) Social Security No. 486-01-7372

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

6. (b) Name of husband or wife Mrs. Lucie J. Morrison 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased January 29th, 1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 02 Days 2 3 hr. min.

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

10. Usual occupation Mailer

11. Industry or business _____

12. Name John W. Morrison

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

14. Maiden name Mollie Prather

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

16. (a) Informant Mrs. Lucie J. Morrison 17

(b) Address 1406 Prospect Avenue

17. (a) Burial (b) Date thereof 4 - 4 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Freeman Mortuary & Chapel

(b) Address 104 West 42nd St. Kansas City, Mo.

19. (a) 4-4-47 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Wm W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 4-2-47

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

MOTHER, FATHER

Dr. Menahan

NOV 19 1957

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *Hannoo 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.