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X 47070

DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS  
FILED APR 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9286**

Registration District No. **147** Primary Registration District No. **1002** Registrar's No. **1415**

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:  
**6321 Morningside Drive**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **none** (Specify whether)  
In this community **21 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. **6321 Morningside Drive** **8**  
(If rural, give location) **0**  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Mrs. Margaret MORRISSEY**  
3. (b) If veteran, name war **no**  
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **march** day **25** **th** year **1947** hour **8** minute **150** P.M.  
21. I hereby certify that I attended the deceased from **3-15-1947** to **3-25-1947** that I last saw him **alive on** and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Peter Morrissey** 6. (c) Age of husband or wife if alive **years**  
7. Birth date of deceased **March 15, 1862**  
(Month) (Day) (Year)

Immediate cause of death **Myocarditis** Duration **3 mo**  
Due to.....  
Due to.....

8. AGE: Years Months Days If less than one day  
**85 0 10** hr. min.

Other conditions **lobar pneumonia** **5 days**  
(Include pregnancy within 3 months of death)

9. Birthplace **Maden Massachusetts**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Housewife**  
11. Industry or business **At home**  
12. Name **James Harrington**  
13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Ellen Regan**  
15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
Major findings:  
Of operations.....  
Of autopsy **no** **108**

16. (a) Informant **Mrs. H. H. Owens**  
(b) Address **5736 Rockhill Rd., KC, Mo.**  
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **3-27-47**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Frankfort, Kansas**

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?

18. (a) Signature of funeral director **Melody-McGilley-Eylar**  
(b) Address **Kansas City, Mo**  
19. (a) **3-26-47** (Date received local registrar) (b) **Heraldine Holme** (Registrar's signature)

23. Signature **H. H. Owens** (M. D. or other) **MO**  
Address **1034 Beato** Date signed **3-25-47**

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

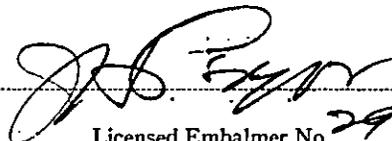
MOYER FATHER

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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.....



Licensed Embalmer No. 2999

P. O. Address..... KC -

**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.**