

S. No. 2
-12-45
5-17-39
P1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH CONSERVATION
FILED MAY 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17545

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2137

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. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 DAYS
 (Specify whether years, months or days) 0 years

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. 1225 PASEO APT. 4
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

WILL MORRIS

3. (b) If veteran, name war no

3. (c) Social Security No. 448-050927

4. Sex MALE
 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Pauline

6. (c) Age of husband or wife if alive conf. years

7. Birth date of deceased MARCH 12, 1900
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 1 28 hr. min.

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

10. Usual occupation LABORER

11. Industry or business _____

12. Name WILLIE GRANT MORRIS

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

14. Maiden name GUSSIE ROSS

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

16. (a) Informant CORA DOUGHERTY (FRIEND)

(b) Address 1225 PASEO

17. (a) Rural (b) Date thereof 5-14-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1212 W. 1st St. Kansas City, Mo.

19. (a) 5-14-47 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 10, year 1947 hour 5: minute 00 A.M.

21. I hereby certify that I attended the deceased from APRIL 29, 1947, to MAY 10, 1947

and that death occurred on the date and hour stated above. I last saw him alive on MAY 10, 1947.

Immediate cause of death UREMIA Duration _____

Due to HYPERTENSION WITH NEPHRITIS

Due to _____

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

Major findings: Of operations 13/0

Of autopsy _____

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? _____

(Specify type of place) While at work _____ Means of injury 0

23. Signature [Signature] (M. D. or M.D.)

Address GENERAL HOSPITAL NO. 2 Date signed 5/12/47

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

MOTHER FATHER

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.....

E. Sterling Bills

Licensed Embalmer No. *3178*

P. O. Address. *1212 Vine St. Kansas City*

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.