

FILED DEC 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41053

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 430

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital Not 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 yrs 1 mo 15 days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 14
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 218 N. Elmwood
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME HENRIETTA MORRIS

3. (b) If veteran, name war _____ 3. (c) Social Security No. Unknown

4. Sex Woman 5. Color or race White 6. (a) Single, widowed, married, divorced widowed 2

6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Feb 5 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 10 4 hr. _____ min.

9. Birthplace Illinois 1
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records

(b) Address Fulton, Mo

17. (a) Removal (b) Date thereof Dec 10-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo.

18. (a) Signature of funeral director R.D. Blackman

(b) Address Kansas City Mo.

19. (a) 2-10-1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9
year 1947 6 hour 30 minute P. M.

21. I hereby certify that I attended the deceased from 1 July
1947, to 9 Dec, 1947.

that I last saw her alive on 9 Dec, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
hypostatic

Due to _____

Due to _____

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

Major findings: _____
Of operations 1110
Of autopsy _____

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

Signature G.S. Warrick (M. D. or other) _____

Address Fulton, Mo Date signed 9 Dec 47

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

RECEIVED
District Health Officer, No. 9,
District File Number
Date Filed 12-17-47

AUG 31 1948

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 O. F. McFarland

Licensed Embalmer No. 4397

P. O. Address 2825 Ind. Blvd., N. C., M

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.