

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12583
1526

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1518 Troost Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) JULIUS	b. (Middle) GENE	c. (Last) MORRISON	4. DATE OF DEATH (Month) (Day) (Year)	MARCH 26 1949
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5. SEX MALE 2	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 17 1868	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) WARRENSBURG, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JOHN MORRISON	13b. MOTHER'S MAIDEN NAME ADA HARLOW	14. NAME OF HUSBAND OR WIFE unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME MAZIE LEACH	ADDRESS 1518 Troost Avenue
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC FAILURE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE TYPE HEART DISEASE WITH DECOMPENSATION DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		1143X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3/9/1949, to 3/26/1949, that I last saw the deceased alive on 3/26/1949, and that death occurred at 2:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis (Degree or title)	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 3/26/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-5-1949	24c. NAME OF CEMETERY OR CREMATORY Kansas University	24d. LOCATION (City, town, or county) (State) LAWRENCE, Kansas
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DATE REC'D BY LOCAL REG. 4-5-49	REGISTRAR'S SIGNATURE Sheldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brady-Brown 1708 Tracy
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed
Student Embalmer

Signed

Lawrence A. Jones Sr.

Licensed Embalmer No. *4429*

P. O. Address *2500 Park Ave. N.E. Wash. D.C. 20018*

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.