

FILED MAR 19 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9998  
State File No. ....  
1212

|   |  |  |  |  |   |  |  |                         |
|---|--|--|--|--|---|--|--|-------------------------|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>149</u>  |  | PRIMARY REG. DIST. NO. <u>1002</u>   |   | Registrar's No. _____  |  |                         |
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> |   |  |  |                         |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>   |  | c. LENGTH OF STAY (in this place) <u>29 YRS.</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>  |   | d. STREET ADDRESS (If rural, give location) <u>3824 MONTGALL</u> <u>3568</u> |  |                         |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>KRESTWOOD MED. HOSPITAL</u>  |  |  |  |  |   |  |  |                         |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>JOHN</u><br>b. (Middle) <u>FRANK</u><br>c. (Last) <u>MORTON</u>   |  |  | 4. DATE OF DEATH <u>FEB. 26 1953</u>                   |  |   |  |  |                         |
| 5. SEX <u>MALE</u> <u>D</u>   | 6. COLOR OR RACE <u>WHITE</u>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>                                  | 8. DATE OF BIRTH <u>12 FEB. 1877</u>                   |  | 9. AGE (In years last birthday) <u>76</u>                                       | IF UNDER 1 YEAR<br>Months  | IF UNDER 1 HR.<br>Hours                  | IF UNDER 1 MIN.<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHARMACIST</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG</u>          |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>CAPE COUNTY, MISSOURI</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |                         |
| 13a. FATHER'S NAME <u>CHARLES MORTON</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN HATCHER</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>HELEN C. MORTON</u>   |   |  |  |                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>  |  | 16. SOCIAL SECURITY NO. <u>489-24-2052</u>   |  | 17. INFORMANT'S SIGNATURE OR NAME <u>H. C. MORTON</u> ADDRESS <u>3824 MONTGALL K.C.</u>  |   |  |  |                         |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Feb 25</u><br><u>1-27-53</u>          |  |                         |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |  |   |  |  |                         |
|   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                              |  |  |  |   | <u>331*</u>  |  |                         |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |                         |
| 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) _____  |   |  |  |                         |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? _____   |   |  |  |                         |
| 22. I hereby certify that I attended the deceased from <u>1-27-53</u> 19 <u>53</u> , to <u>2-26-53</u> , that I last saw the deceased alive on <u>2-25-53</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above. |  |  |  |  |   |  |  |                         |
| 23a. SIGNATURE <u>H. C. Morton M.D.</u> (Degree or title)   |  |  |  | 23b. ADDRESS <u>3824 Montgall</u>  |   | 23c. DATE SIGNED <u>2-27-53</u>  |  |                         |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 24b. DATE <u>28 FEB. 53</u>  | 24c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS</u> |  | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>           |  |  |                         |
| DATE REC'D BY LOCAL REG. <u>2-27-53</u>   |  | REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>FLORAL HILLS MEMORIAL CHAPELS K.C.</u> ADDRESS _____   |   |  |  |                         |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
B. Atcheson MD

STATE OF MISSOURI  
DEPARTMENT OF HEALTH

CERTIFICATE

For *Anderson* 2850 *Princeton*

**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.

Student .....  
Student Embalmer

Signed

*Lloyd C. McCord*

Licensed Embalmer No. *4853*

P. O. Address *K.C. 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.