

FILED AUG 29 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27053

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3417

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If instituting Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Golden Age Rest Home</u>		Length of stay in lb <u>39 yrs.</u>	d. STREET ADDRESS <u>3817 East 68th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>G</u> Last <u>MORGAN</u>			4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1881</u>	9. AGE (In years last birthday) <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration Engineer &amp; Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>new Logansport, Ind.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reese</u>			14. MOTHER'S MAIDEN NAME <u>alice Carigan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>487-01-1401</u>	17. INFORMANT Address <u>3817 EAST 68th St. KANSAS CITY, MO.</u> <u>MRS. ANNA L. MORGAN</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchial Pneumonia due to fall</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>It is suspected Brain Tumor - x-ray negative</u> DUE TO (c) <u>Accident while in bed</u>					INTERVAL BETWEEN ONSET AND DEATH <u>of days</u> <u>negative</u> <u>09027</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Accident while in bed</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell out of bed.</u>				
20c. TIME OF INJURY Hour <u>Ang 4</u> Month, Day, Year <u>56</u> a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>nursing home</u>		20f. CITY, TOWN OR LOCATION <u>2905 Campbell Jackson MO</u>		20g. COUNTY STATE <u>JACKSON MO</u>	
21. I attended the deceased from <u>1947</u> to <u>date of death</u> and last saw him alive on <u>Aug 9/1956</u> ✓ Death occurred at <u>2:55 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James J Ferguson M.D.</u>			22b. ADDRESS <u>410 Brynart Blvd</u>		22c. DATE SIGNED <u>Aug 7/56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-7-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, mo.</u>	
24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS</u>		ADDRESS <u>1731 K.P. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-7-56</u>		26. REGISTRAR'S SIGNATURE <u>New Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
James T. Ferguson, M.D.

MEDICAL CERTIFICATION

300  
1-56Health,  
Welfare  
Public  
Service

AUG 23 1956

42-1330

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.....  
Signature of Student Embalmer

Signed.....  
*Kallie Kessel*

Licensed Embalmer No. 469

P. O. Address.....  
K.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.