

STANDARD CERTIFICATE OF DEATH

28454

STATE FILE NUMBER

FILED AUG 23 1957

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 164

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ja. Co. Hosp.		d. STREET ADDRESS (If outside, give location) Ja. Co. Hospital	
3. NAME OF DECEASED (Type or print) First Rosalie Middle L. Last Morrison		4. DATE OF DEATH Month 8 Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1864
9. AGE (In years last birthday) 93		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cairo, Ill.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel Lindsey		14. MOTHER'S MAIDEN NAME Ann. M. Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT County Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. E. Nelson Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Asthenia Senilis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) Pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input 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.)
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from Aug 1, 56 to Aug. 12, 57 and last saw her/him alive on Aug 12, 57 Death occurred at 9:03 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Donald Williams M.D. (Degree or title)		22b. ADDRESS Jordan County	
22c. DATE SIGNED 8-12-57			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8-14-57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) K. C. MO.
24. FUNERAL DIRECTOR Stone-McClure ADDRESS K. C. MO.		25. DATE RECD. BY LOCAL REG. 8-13-1957	26. REGISTRAR'S SIGNATURE N. B. Longford

(Licensed Embalmer's Statement on Reverse Side)

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

MEDICAL CERTIFICATION

AUG 20 1957

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 *Engene L Kennon*.....

Licensed Embalmer No. *46*

P. O. Address *K.C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.