

Health,  
& Welfare  
S. Public  
th Services

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v. 1-56

Warning: The medical certificate in this form is required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43549  
STATE FILE NUMBER

FILED JAN 6 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1424

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence 3311 St. Joseph Ave</b>				Length of stay in lb <b>10 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>3311 St. Joseph Ave</b>			
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>I.</b> Last <b>MORRIS</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1957</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29, 1876</b>			
9. AGE (In years last birthday) <b>81</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Veterinary</b>		11. BIRTHPLACE (City and state or country) <b>Gentry Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				13. FATHER'S NAME <b>James Morris</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) <b>No</b>				14. MOTHER'S MAIDEN NAME <b>MARY Ellenderidge</b>		17. INFORMANT Address <b>St. Joseph, Mo.</b> <b>Mrs. Chas. O'Neil 3311 St. Joseph Ave.</b>			
16. SOCIAL SECURITY NO. <b>None</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>331X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years</b>	
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 _____ 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, etc., office bldg., etc.) <b>3311 St. Joseph Ave</b>					
20f. CITY, TOWN, OR LOCATION <b>St. Joseph</b>		COUNTY <b>Buchanan</b>		STATE <b>MO</b>					
21. I attended the deceased from <b>Dec. 20, 57</b> to <b>Dec. 24, 57</b> and last saw <sup>her</sup> him alive on <b>Dec. 25, 57</b> Death occurred at <b>1:00 A. m</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Thomas E. Kennedy M.D.</b>				22b. ADDRESS <b>214 Park Parkway, St. Joseph, Mo.</b>		22c. DATE SIGNED <b>Dec 24 1957</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/24/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King City Cem.</b>		23d. LOCATION (City, town, or county) <b>King City, Mo.</b>			
24. FUNERAL DIRECTOR <b>Harold E. Kessler</b>				ADDRESS <b>King City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec 27 1957</b>			
26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>									

(Licensed Embalmer's Statement on Reverse Side)

Dr. S E Melaney  
Kiepkateck Bldg.  
7<sup>th</sup> & FRANCIS

REVISED JAN 1958

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 *Harold E. Koobel*

Licensed Embalmer No. *4609*

P. O. Address *King City*

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.