

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021570

FILED JUL 13 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 3175

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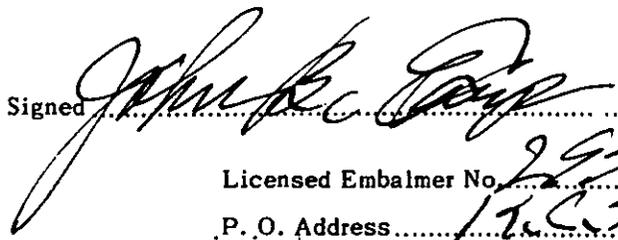
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2507 Lister</b>	
3. NAME OF DECEASED (Type or print) First <b>Rilla</b> Middle <b>Inez</b> Last <b>Morgan</b>		4. DATE OF DEATH Month <b>6</b> Day <b>27</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
13a. FATHER'S NAME <b>Thomas D. Chaffee</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Poole</b>	14. NAME OF HUSBAND OR WIFE <b>Daniel Morgan</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Raymond Morgan 2507 Lister</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>Myocardial Infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 260</b>
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 <b>6-24-59</b> , to <b>6-27-59</b> and last saw her alive on <b>6-27-59</b> Death occurred at <b>4:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Abraham Galperin</b>		22b. ADDRESS <b>General Hospital</b>	
22c. DATE SIGNED <b>6-29-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>6-30-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Earp &amp; Sons Kansas City, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-29-59</b>	26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b>

Abraham Galperin M.D. must be causally related. MEDICAL CERTIFICATION

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  .....  
Licensed Embalmer No. 2955  
P. O. Address 1212 S. 7th

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.