URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 10 1959

59–040246

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5690

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City,
Length of stay in 1b 54 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jodaway
c. CITY OR TOWN Hopkins,
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) General Delivery
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Guy Middle Last Morris
4. DATE OF DEATH Month 11th Day 23rd Year 1959

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 12-26-84
9. AGE (last birthday) 74 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (City and state or country) Athelston, Iowa
12. CITIZEN OF WHAT COUNTRY U S

13a. FATHER'S NAME William Morris
13b. MOTHER'S MAIDEN NAME Martha Freemyer
14. NAME OF HUSBAND OR WIFE Delia M. Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 9-17-17 to 5-20-19
16. SOCIAL SECURITY NO. 495389814
17. INFORMANT V.A. Hospital Records, K.C.,Mo Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, RML, RLL & LLL
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Bronchial carcinoma, RLL
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 (a)
Probable pulmonary tuberculosis, LLL

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 September 29,1959 to November 23,1959 and last saw him alive on
Death occurred at 11:2 0pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. A. TURNER MD (Degree or title) MD
22b. ADDRESS V.A. Hospital,K.C.,Mo.
22c. DATE SIGNED 11-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE NOV 24, 1959
23c. NAME OF CEMETERY OR CREMATORY HOPKINS CEM
23d. LOCATION (City, town, or county) HOPKINS MISSOURI (State)

24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS K. C. MO. ADDRESS
25. DATE RECD. BY LOCAL REG. 11-25-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

APR 19 1980

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4421

P. O. Address _____

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