

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-001766
73 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 73

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| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: 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> | | Length of stay in 1b <u>3 mo.</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>8132 Highland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Verna</u> Middle <u>Morris</u> Last <u>Morris</u> | | | 4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>4-7-93</u> | 9. AGE (last birthday) <u>66</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CARTHAGE, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | |
| 13a. FATHER'S NAME <u>F. G. Robinson</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</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>NONE</u> | | 17. INFORMANT Address <u>Austin Funeral Home - Hale Mo.</u> | | |

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| 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>METASTATIC CARCINOMA</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1Y</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>CARCINOMA of CERVIX</u> | | <u>1Y</u> |
| | DUE TO (c) | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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 <u> </u> Month, Day, Year <u> </u> 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 Oct 1954 to 1-5-60 and last saw her live on 1-5-60
Death occurred at 5:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>B. Marcus Heller M.D.</u> | | 22b. ADDRESS <u>409 E. 63rd</u> | | 22c. DATE SIGNED <u>1-6-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>1/6/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Hale Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Sheil Funeral Home K.P. Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-6-60</u> | 26. REGISTRAR'S SIGNATURE <u>Irena Marshall</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

B Marcus Heller

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 Richard E. Carroll

Licensed Embalmer No. 482

P. O. Address K. C. Mo

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.