

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034930

FILED VS OCT 1 0 1960

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Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 4840 STATE FILE NUMBER _____

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>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in lb <u>hours</u>	c. CITY OR TOWN <u>Liberty</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>Resarch Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>S.</u> Last <u>Morris</u>	4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1960</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-76</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>painting</u>	11. BIRTHPLACE (City and state or country) <u>Clay Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph D. Morris</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Bertha Ferril Morris</u>
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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>unknown</u>	17. INFORMANT <u>Bertha F. Morris</u> Address <u>Liberty, Missouri</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>Coronary Occlusion</u> DUE TO (b) <u>with Myocardial Infarction</u> DUE TO (c) <u>Coronary Sclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5yr</u>
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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) <u>Hypertensive Cardiovascular disease</u>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY PERFORMED 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 _____
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21. I attended the deceased from <u>Sept 1, 1960</u> to <u>Sept 23, 1960</u> and last saw her alive on <u>Sept 22, 1960</u> Death occurred at <u>5:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James W. Willoughby M.D.</u> (Deceased or title)	22b. ADDRESS <u>Liberty, Mo.</u>	22c. DATE SIGNED <u>9-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>
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24. FUNERAL DIRECTOR <u>Tyler-Pasley</u> ADDRESS <u>Liberty, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>9-24-60</u>	26. REGISTRAR'S SIGNATURE <u>H-L Dwyer</u>
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DOCUMENT

BY AFFIDAVIT OF James W. Willoughby, M.D. 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles J. Tyler

Licensed Embalmer No. 453

P. O. Address Liberty

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.