OCT 19 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

2

1. PLACE OF DEATH
County Jackson | Registration District No. 399 | File No. 33208
Township Raw | Primary Registration District No. 1002 | Registered No. [illegible]
City K. C. Mo (No. General Hospital St. Ward)

2. FULL NAME Katherine Morgan
(a) Residence, No. 1205 Troost St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-22-1904

7. AGE 55 | YEARS 33 | MONTHS 6 | DAYS 13 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Typist
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER
13. NAME Chas. F. Morgan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Barbaria Tergens
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Wm C. Morgan 116 West High Spr. Ohio

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Lawn DATE Sept 9 1937

19. UNDERTAKER (ADDRESS) A. P. Doehler 1415 East 15

20. FILED Sept 7 1937 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 5, 1937

22. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19..., I last saw alive on ....., 19..... Death is said to have occurred on the date stated above, at 11 30 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Sclerosis — Arteriosclerosis
Cerebral Encephalomalacia
87B

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Russell W. Kerr M. D.
(Address) K. C. Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.