

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.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: At Home 4029 Flora  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 Yrs.  
In this community 7 Yrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Carol Ann MORGAN 625

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: December 17, 1932.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>--</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation School Girl

11. Industry or business \_\_\_\_\_

12. Name Joseph C. Morgan  
13. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Josephine Prothman  
15. Birthplace Omaha, Nebraska  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph C. Morgan  
(b) Address 4029 Flora, Kansas City, Mo.

17. (a) Burial (b) Date thereof Jan. 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Melody-McGilley  
(b) Address Kansas City, Mo.

19. (a) Jan. 15, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4029 Flora  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 12  
year 1940 hour 9<sup>00</sup> minute 9 M.

21. I hereby certify that I attended the deceased from 1/7/40  
\_\_\_\_\_, 19\_\_\_\_, to 1/12, 19\_\_\_\_  
that I last saw her alive on 1/12, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Evaluation  
Duration Instant

Due to Arteriosclerosis  
Central Pneumonia today  
Due to Pneumonia

Other conditions 105  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) No  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Philip Bell (M. D. or other) \_\_\_\_\_  
Address 3034 Harrison Date signed 1/14/40

PHYSICIAN  
Underline the cause to which death should be charged statistically.

Hull  
515 W. 1st St.

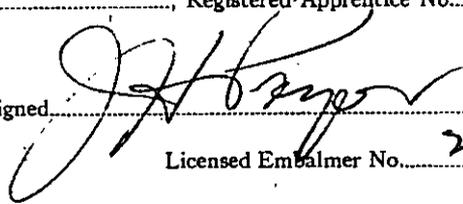
**STATEMENT BY LICENSED EMBALMER**

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

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No..... 2999

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**