WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1946

State File No. 40606

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 1387

**1. PLACE OF DEATH:**

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: four days (Specify whether years, months or days) In this community: Worked & lived at Hosp. for 7 months

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Kansas (b) County: Miami 11

(c) City or town: Osawatomie 1
(If outside city or town limits, write "RURAL")

(d) Street No. 7
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: ~~ALBERT D. MORRIS~~ ~~ALFRED D. MORRIS~~

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife: (No information)

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: 2 (Month) 22 (Day) 75 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 10 | 3 | hr. min. |

9. Birthplace: Illinois (City, town, or county) / (State or foreign country)

10. Usual occupation: hydrotherapist

11. Industry or business: State Hosp. # 2, St. Joseph

12. Father's name: Alfred Morris

13. Birthplace: Virginia (City, town, or county) / (State or foreign country)

14. Maiden name: Louise Acker

15. Birthplace: Virginia (City, town, or county) / (State or foreign country)

16. (a) Informant: daughter, Alice Grimes

(b) Address: Osawatomie, Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-26-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Osawatomie Ks.

18. (a) Signature of funeral director: Fleeman & Son Inc

(b) Address: St Joseph, Mo.

19. (a) Dec. 26 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12 day 25 year 1945 hour 9:35 minute P. M.

21. I hereby certify that I attended the deceased from 12-21-45, 19..., to 12--25-45, 19...; that I last saw him alive on 12-25-45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: cerebral hemorrhage — Duration

Due to: skull fracture

Due to:

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

Major findings: Of operations:

Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: 131

(a) Accident, suicide, or homicide (specify):

(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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [illegible] M.D.

Address: State Hosp. No. 2 - St. Joseph Date signed: 12/26/45

Corrected 1-18-46 Kansas

148

(Licensed Embalmer's Statement on Reverse Side)

JAN 19 1946

JAN 18 1946

JAN 10 1946

## 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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

State of Missouri
County of Buchanan } ss.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

**AFFIDAVIT FOR CORRECTION OF A RECORD**

State File No.
Local Registrar's No. 1387

On this 15th day of Jan., 1946, before me appears William J. Fleeman, Jr., who, upon his oath, states that the original record of ~~birth~~ death for Albert D. Morris died December 25, 1945 in the State of Missouri, and which was filed at St. Joseph, Mo. on Dec. 26, 1945, should be corrected as follows:

Item No. 3 (a) should read Albert D. Morris

Instead of Alfred D. Morris

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

Item No. should read

Instead of

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant FLEEMAN AND SON, INC. W. J. Fleeman Jr. Sec. Pres. Relationship.

1946 Colhoun Street
Present Address.

Subscribed and sworn to before me this 15th day of January, 1946

My Commission expires April 23, 1946 Elizabeth C. McAllister Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

V. S. 135
—4-43
I X36667

406606

2B
45
43860

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1387

**1. PLACE OF DEATH:**

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Work. no 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alfred D. Morris

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 22 (Day) 1872 (Year)

8. AGE: Years 70 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 25 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to cerebral hemorrhage

Due to

Other conditions fractured skull
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: combination of cerebral hemorrhage
(a) Accident, suicide, or homicide (specify) & fractured skull
(b) Date of occurrence December 25, 1945
(c) Where did injury occur? St. Joseph, Buchanan, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? his room in dormitory at place of work (Specify type of place)
While at work? no (e) Means of injury believe he fell after cerebral hemorrhage strikin head and causing skull fracture

23. Signature (M.D. or other) M.D.

Address State Hospital No. 2 St. Joseph, Mo. Date signed 1-11-46

SUPPLEMENTARY

40606