

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5687**

BIRTH NO. FILED FEB 23 1954 REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052** Registrar's No. **910**

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sedalia</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>Sedalia</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>514 W-6th</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or Print) a. (First) <b>Helen</b> b. (Middle) <b>Elizabeth</b> c. (Last) <b>MORRISON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb 14 1954</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Sept 18 1906</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City, and State or Foreign Country) <b>Sedalia Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Henry Busch</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Hoehns</b>	14. NAME OF HUSBAND OR WIFE <b>George H. Morrison</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>49P-07-4761</b>	17. INFORMANT'S SIGNATURE OR NAME <b>George Morrison</b> ADDRESS <b>Sedalia</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subarachnoid haemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 30, 1954**, to **Feb 14, 1954**, that I last saw the deceased alive on **Feb 14, 1954**, and that death occurred at **10:20A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Chas. Dornan Kaufman M.D.</b>	23b. ADDRESS <b>Sedalia Mo</b>	23c. DATE SIGNED <b>2-15-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2-17-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Crossin Hill</b>
24d. LOCATION (City, town, or county) (State) <b>Sedalia MO</b>		

DATE REC'D BY LOCAL REG. <b>2-17-54</b>	REGISTRAR'S SIGNATURE <b>R. G. Campbell M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>McL...</b> ADDRESS <b>Sedalia</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

[JUN 2 1959]

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**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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *K P M Crary*

Licensed Embalmer No..... *1315*

P. O. Address..... *DeDalia*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.**