

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34055**
4910

FILED NOV 10 1954
BIRTH NO. 78145-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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

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>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>1130 - East Fourth</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Conley Maternity Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BABY</u>		b. (Middle) <u>BOY</u>	
c. (Last) <u>MORRISON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 8 - 54</u>	
5. SEX <u>0</u> <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>10 - 6 - 54</u>
9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 2 Wks. Days	IF UNDER 24 Hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Walter Frank Morrison, Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Carol McCollister</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Walter F. Morrison</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis of the Lungs</u> ANTECEDENT CAUSES DUE TO (b) <u>Aspiration Pneumonia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Subdural Hemorrhage</u> 18. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prematurity</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 <u>10 - 6</u> , 19 <u>54</u> , to <u>10 - 8</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10 - 8</u> , 19 <u>54</u> , and that death occurred at <u>10:40 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Luther W. Swift</u>		23b. ADDRESS <u>2105 Independence Ave.</u>	
23c. DATE SIGNED <u>10-12-54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Destroyed at laboratory of Conley Hospital</u>	
24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Conley Laboratory</u>	
25. ADDRESS <u>K. C. Mo.</u>		DATE REC'D BY LOCAL REG. <u>10-25-54</u>	
REGISTRAR'S SIGNATURE <u>neva minshall</u>			

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
Student Embalmer

Signed.....

Licensed Embalmer No.

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, fact should be so stated above.