

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041133

FILED VS. DEC 14 1959 251

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 250

ENDED

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>White Cloud Twp.</u>		Length of stay in 1b -----	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway 71</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4729 Charlotte</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>COPE</u> Last <u>MORRELL</u>			4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/27</u>	9. AGE (last birthday) <u>32</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Collins Carlyle</u>		11. BIRTHPLACE (City and state or country) <u>Denver, Colo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>L. B. Morrell</u>		13b. MOTHER'S MAIDEN NAME <u>Alberta Cope</u>		14. NAME OF HUSBAND OR WIFE <u>Barbara Morrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>11</u>		17. INFORMANT Address <u>Mrs. W. C. Morrell, Kansas City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Brain stem laceration</u>					<u>Instant</u>
DUE TO (b) <u>Fractured cervical spine</u>					" "
DUE TO (c) _____					" "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Compound fractures of both legs - internal injuries</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Head on collision of her car & another car</u>			
20c. TIME OF INJURY <u>5:15 p.m.</u>	Month, Day, Year <u>12 4 1959</u>				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 71</u>	20f. CITY, TOWN, OR LOCATION <u>Hi 71-18 mi. S. Maryville, Nodaway</u>		COUNTY <u>MO.</u>	STATE
21. I attended the deceased from <u>5:15 P.</u> to <u>12/4/59</u> and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B. J. Byland M.D.</u> (Degree or title)			22b. ADDRESS <u>Maryville, Missouri</u>		22c. DATE SIGNED <u>12/5/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12/5/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		23d. LOCATION (City, town, or country) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>Price Funeral Home, Maryville, Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Gess Holt</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OSM #1 020 SN'

FEB 10 1960

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 John W. Price

Licensed Embalmer No. 4281

P. O. Address Maryville

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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

