

RECD JUN 8 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17546
Do not use this space.

1948

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. St. Joseph Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Infant Austin

(a) Residence, No. 143 S. Bellaire St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF --
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 8, 1939
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 3 hrs. or min. 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Missouri
 13. NAME O. W. Austin
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 MOTHER 15. MAIDEN NAME Helen Harrow
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 17. INFORMANT O. W. Austin
 (ADDRESS) K. C. Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Washington Cem. DATE May 10-39

19. FUNERAL DIRECTOR (NAME) C. H. Blackman & Son, Inc.
 (ADDRESS) 2825 Indep. Blvd. K. C. Mo.

20. FILED May 9, 1939 M. M. Brown
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-8-39 to 5-8-39
 I last saw her alive on 5-8-39 Death is said to have occurred on the date stated above, at 2 P.M.

The principal cause of death and related causes of importance were as follows:

atelectasis
(non-expansion of lungs in new born)
1939

Date of onset 5-8-39

Other contributory causes of importance:
Paranasal sinuses not closed

Name of operation none Date of
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury , 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) A. Carney, M.D.
 (Address) 6520 Independence Ave.

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.

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.....

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.