

JAN 13 1940
Registration District No. 399

Primary Registration District No. 1002

State File No. _____
Registrar's No. 4988

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(c) Name of hospital or institution: General Hospital No. 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12-20 to 12-24-39
(Specify whether
In this community 4 days
years, months or days)

3. (a) PRINT FULL NAME Infant Henderson 53
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 12 20 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 4 hr. _____ min.

9. Birthplace Kansas City Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address General Hospital #2

17. (a) General (b) Date thereof 1-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Red 2 St

18. (a) Signature of funeral director Wm. L. Brown

(b) Address 12 E. 16th St

19. (a) Dec. 31, 1939 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1014 E. 16th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 24
year 39 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from 12-20-, 1939 to 12-24, 1939
that I last saw him alive on 12-24-, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho-Pneumonia

Due to None

Due to 107a

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

Major findings: Of operations _____

Of autopsy Above mentioned.

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

(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 W. L. Brown (M. D. or other) _____
Address General Hospital #2 Date signed 12-29

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.