

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
Kansas City
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community same
years, months or days)

3. (a) PRINT FULL NAME Myers infant (male)

3. (b) If veteran, name war -- 3. (c) Social Security No. ---

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Feb. 19th 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 hr. min.

9. Birthplace K.C. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Raymond L. Myers
13. Birthplace Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Leona Rose
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address K.C. Gen. Hospital

17. (a) Burial (b) Date thereof 2-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation See 23

18. (a) Signature of funeral director Wm. A. ...

(b) Address K.C. Gen. Hospital

19. (a) Feb. 28, 1940 (b) M. H. Brown
(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. 3014 Garfield
(If rural, give location)
(e) If foreign born, how long in U. S. A. --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 22nd
year 1940 hour --- minute --- M.

21. I hereby certify that I attended the deceased from Feb. 19th, 1940, to Feb. 22nd, 1940; that I last saw him alive on Feb. 22nd, 1940, 19---; and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage

Due to 160/110

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

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?

While at work? (Specify type of place) (e) Means of injury ---

23. Signature P. De ... (M. D. or other)
Address Supt. K.C. Gen. Hospital Date signed ---

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.