

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1544

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hosp 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town K.C.
(If outside city or town limits write "RURAL")

(d) Street No. 3305 Paseo
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Un infant Swallow
Un named - Swallow

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 15
year 40 hour 6 minute 90 a.m.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased 3 - 14 - 40
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

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

0 0 0 8 hr. 30 min.

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

Immediate cause of death: still birth
Prematurity
129 5 1/2 months pregnancy

Due to _____

Due to _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Rud Newton Swallow

13. Birthplace Barana Kansas
(City, town, or county) (State or foreign country)

14. Maiden name Arroy Family

15. Birthplace Blue Rapids Kansas
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Rud Swallow

(b) Address 3305 Paseo

17. (a) Cremation (b) Date thereof 3 - 15 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hosp

18. (a) Signature of funeral director None

(b) Address None

19. (a) April 9, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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 _____

28. Signature Rud N. Swallow (M. D. or other) MD

Address 910 P. ... Date signed _____

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.