

No. 2  
-10-39  
7-30  
X21452

SEP 5 1940

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3405

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:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hours  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Craig  
(If outside city or town limits, write "RURAL")  
(d) Street No. X  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? No. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August, day 30th,  
year 1940 hour 3:45 minute 9 P. M.  
21. I hereby certify that I attended the deceased from 3:45 PM  
8/29, 1940 to 9 PM 8/29, 1940.  
that I last saw him alive on 8/29, 1940  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Baby Cies. (infant)  
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased: August 29 1940  
(Month) (Day) (Year)

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

9. Birthplace: Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business X

MOTHER FATHER { 12. Name Robert S. Cies  
13. Birthplace: Missouri (City, town, or county) (State or foreign country)  
14. Maiden name Ruth Maser  
15. Birthplace Kansas (City, town, or county) (State or foreign country)

16. (a) Informant Robert S. Cies  
(b) Address Craig, Mo.

17. (a) Removal (b) Date thereof 8-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: Burial or cremation Craig, Mo.

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Aug. 30, 1940 (b) M. D. Cassie  
(Date received local registrar) (Registrar's signature)

Immediate cause of death: Premature  
6 1/2 mos. gestation  
Due to Placenta Praevia Centralis  
hemorrhage  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Edwin Caldwell (M. D. or other)  
Address 1032 Prof Date signed 8/30/40

PHYSICIAN  
- 159  
Underline the cause to which death should be charged statistically.

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

**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 E. M. Plouffe

Licensed Embalmer No. 1848

P. O. Address K. C. 720

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**