DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30907

Registration District No. 399 (OCT 11 1940)

Primary Registration District No. 1002

Registrar's No. 3470

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: The Willows
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 (Specify whether 1
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2929 Main Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Phyllis Koger

3. (b) If veteran, name war --

3. (c) Social Security No. infant

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife infant infant

6. (c) Age of husband or wife if alive yes years

7. Birth date of deceased Aug. 18, 1940 (Month) (Day) (Year)

8. AGE: Years | Months | Days 16 | If less than one day hr. min.

9. Birthplace Willows Hospital (City, town, or county) 0 (State or foreign country)

10. Usual occupation infant 9

11. Industry or business infant

FATHER
12. Name unknown 0
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emma Dee Koger
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. U. Dysart, R. N.
(b) Address 2929 Main Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4-40 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Eylar Funeral Home
(b) Address 1800 Linwood K.C.Mo.

19. (a) Sept. 4, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3rd year 1940 hour 5:00 P. M minute M.

21. I hereby certify that I attended the deceased from Aug. 18, 1940, to Sept. 3, 1940; that I last saw her alive on Sept. 3, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity six-one half to seven months' Gest.

Due to Congenital Syphilis

Due to

Other conditions Maternal Wass. four plus
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓

Of autopsy none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

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 1

23. Signature H. L. Dwyer (M. D. ~~or other~~)
Address 315 Alameda Road Date signed 9-4-40

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

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