

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34554

Registrar's No. 4070

NOV 12 1940

Registration District No. 333

Primary Registration District No. 1002

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Kirkendall, Infant

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro
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 10-22-40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 5 min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER { 12. Name John Kirkendall
FATHER { 13. Birthplace Kansas City, Mo.
(State or foreign country)
14. Maiden name Julia Dawson
15. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Kirkendall

(b) Address 2400 Highland Ave

17. (a) Burial (b) Date thereof Oct. 23-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director W. H. ...

(b) Address 905 ...

19. (a) 10-23-40 (b) M. M. Glowe
(Date received local registrar) (Registrar's signature)

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. 2422 Woodland
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1940 hour 2:35AM minute _____ M.

21. I hereby certify that I attended the deceased from October 21, 1940 to October 22, 1940
that I last saw him alive on October 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Premature

Due to _____

Due to _____

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature W. H. ... (M. D. or other)

Address Mo Mo Date signed _____

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.

1 X1951

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.....

P. H. Huet

Licensed Embalmer No. *2710*

P. O. Address *R. C. 7110*

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.