

REC'D MAR 14 1941

Registration District No. 379

Primary Registration District No. 1002

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

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: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hours
(Specify whether years, months or days)
In this community 8 hrs

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. 802 Vasco
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thompson infant

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

4. Sex ♂ 5. Color of race White (e) Single, widowed, married, divorced 0

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

7. Birth date of deceased February 19, 1941
(Month) (Day) (Year)

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

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

10. Usual occupation None

11. Industry or business _____

12. Name Allen Thompson

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

14. Maiden name Ariel Brown

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Ariel Thompson

(b) Address 802 Vasco

17. (a) Removal (b) Date thereof 2-19-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shannon Home

18. (a) Signature of funeral director C.H. Blackburn

(b) Address 2525 Ind. Blvd.

19. (a) 2/19/41 (b) M. M. Crone
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19th
year 1941 hour 8 minute 35 A.M./P.M.

21. I hereby certify that I attended the deceased from 2-19-41 to 2-19-41
that I last saw her alive on 2-19-41
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity-7 months infant

Due to _____

Due to _____

Other conditions 15A
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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 Dwight R. Shaw (M. D. or other) _____

Address Med. Dir. K.C. Gen. Hospital Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, fact should be so stated above.