

FILED MAY 16 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

13524

Registration District No. 299

Primary Registration District No. 1002

Registrar's No.

1505

## 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 4-8-41-4-10-41  
 (Specify whether years, months or days)  
 In this community 2 days

3. (a) PRINT FULL NAME Infant Boston

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased. 4 8 1941  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
0 0 2 hr. min.9. Birthplace Kansas City Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation None

11. Industry or business

MOTHER FATHER  
 12. Name Nathaniel Boston  
 13. Birthplace Miss.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Fannie Smith  
 15. Birthplace Miss.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk  
(b) Address Gen. Hosp. #217. (a) Burial (b) Date thereof 4-17-41  
(Burial, cremation, or removal) (Month) (Day) (Year)18. (a) Signature of funeral director Wm A Schuyler  
(b) Address 116 Gen Hosp19. (a) Apr 16, 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1115 Lydia Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 0 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 10  
year 41 hour 1 minute 25 A.M.21. I hereby certify that I attended the deceased from  
4-8-, 1941, to 4-10-, 1941;  
that I last saw her alive on 4-10-, 1941;  
and that death occurred on the date and hour stated above.Immediate cause of death Premature Birth DurationDue to 159Due to 159Other conditions 159  
(Include pregnancy within 3 months of death)Major findings: 159  
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 023. Signature P. C. [unclear] (M. D. or other) 0  
Address Gen. Hosp #2 Date signed 4-10-41

PHYSICIAN

Underline the cause to which death should be charged statistically

(Licensed Embalmer's Statement on Reverse Side)

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**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.**