

1941 AUG 10 1941
Registration District No. 9

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(d) Length of stay: In hospital or institution 1 day
In this community 0 years, months or days

3. (a) PRINT FULL NAME Wyatt infant
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race White 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 June 12th 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day _____ hr. _____ min.

9. Birthplace K.C. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____
12. Name Unknown
13. Birthplace Unknown
14. Maiden name Iva Wyatt
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K.C. General Hospital, K.C. Mo.

17. (a) Burial (b) Date thereof 7-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reburied

18. (a) Signature of funeral director [Signature]
(b) Address Med. Dir. K.C. Gen. Hospital

19. (a) 7-2-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 4722 Troost Avenue
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13th
year 1941 hour 1 minute 55 A.M. M.

21. I hereby certify that I attended the deceased from 6-12-41 to 6-13-41
that I last saw her alive on June 13th, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURITY

Due to _____
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) (State)
(c) Means of injury _____
23. Signature [Signature] (M. D. or other) D
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration _____
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.