No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 10 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24067

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2606

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 No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ——
(Specify whether years, months or days)
In this community: 0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 048

(c) City or town: Kansas City 3 6
(If outside city or town limits, write "RURAL")

(d) Street No.: 5625 E. Penn St.
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Boots infant

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

4. Sex: Male 0 | 5. Color or race: W | 6. (a) Single, widowed, married, divorced: W. 1

6. (b) Name of husband or wife: —— 6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: June 11th, 1941 (Month) (Day) (Year)

8. AGE: Years ——— | Months | Days | If less than one day: ____ hr. √ min.

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

10. Usual occupation: home —

11. Industry or business: ____

FATHER
12. Name: Claude Hess Boots
13. Birthplace: Amoret Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Wilma Maxine Dunlap
15. Birthplace: Kokomo, Indiana 1
(City, town, or county) (State or foreign country)

16. (a) Informant: Mother, Mrs. Wilma Dunlap
(b) Address: 5625 E. 10th St., K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-3-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Leeds, Mo.

18. (a) Signature of funeral director: Wm. A. Lohmeyer
(b) Address: city

19. (a) 7-11-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11thh year 1941 hour 6 minute 37 P. M.

21. I hereby certify that I attended the deceased from 6-11-41, 19__, to 6-11-41, 19__; that I last saw him alive on 6-11-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity—approx. 26 wks. gestation Baby born with pulse of 80 but did not breathe.	
Due to: Premature separation of placenta	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: ____
Of autopsy: See above

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: ____

23. Signature: Drury R. Thom (M. D. or other) D
Address: Med. Dir. K.C. Gen. Hospital Date signed: ____

361 (Licensed Embalmer's Statement on Reverse Side)

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24067

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2606

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 Hosp. No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Boots Infant
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)

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

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

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

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 9/11/41 (Date received local registrar) (b) R. R. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day ..... year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h. ..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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 .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

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

Med. Dir. K.C. Gen. Hospital