

No. 2
1-4-41
1-17-39
X2690

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40805**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4481**

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 No. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 hrs 0 (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **048**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL") **8**
 (d) Street No. General Hospital No. 2
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME INFANT TABORN

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

4. Sex Male 5. Color or race Negro 6. (a) Single Infant 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 Nov 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. — 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 Unknown

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

14. Maiden name Mildred Taborn

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 12-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reel 5 P

18. (a) Signature of City Director Wm. A. Thomas
 (b) Address City Medication

19. (a) 12/3/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
 year 1941 hour 6 minute 15 a. M.

21. I hereby certify that I attended the deceased from 11-24-41
11:50 p.m. 19— to 6:15 a.m. 19—;
 that I last saw him alive on November 24 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
Six (6) months

Due to 159

Due to —
 Other conditions —
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations —
 Of autopsy —
 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? — or Means of injury —

23. Signature J. O. Thomas (M. D. or other) 0
 Address Gen. Hosp. #2-6006-22 Date signed 11-27-41

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

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.