

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40862

State File No. _____

FILED JAN 24 1943
Registration District No. 999

Primary Registration District No. 1002

Registrar's No. 4538

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 2 days
(Specify whether)

In this community 12 Mos. 0 years, months or days

3. (a) PRINT FULL NAME Carolyn Sue Little

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 5. Color or race W

6. (a) 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 SEPT 10 1940
(Month) (Day) (Year)

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

1 2 28 hr. 0 min.

9. Birthplace Tambaska Okla
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name D. Neil Little

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

14. Maiden name Mary Bailey

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

16. (a) Informant Neil Little

(b) Address 1724 Corrington

17. (a) Burial (b) Date thereof Dec 9-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Okla

18. (a) Signature of funeral director Sheel August Home

(b) Address Kansas City Mo

19. (a) 12/8/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City
(If outside city or town limits, write "RURAL") 5

(d) Street No. 1724 Corrington
(If rural, give location) 8

(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th
year 1941 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from 12-6-41, 19____, to 12-8-41, 19____;
that I last saw her alive on 12-8-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumococcic meningitis

Due to Strep

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

See above

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 Wray Nelson (M. D. or other) _____
Address Med. Dir. K. C. General 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.