

REG. MAR 9 1949
Registration District No. _____

Primary Registration District No. 1002

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: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12-31-41-2-4-42
(Specify whether years, months or days)

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

3. (a) PRINT FULL NAME INFANT DRAPER
(b) If veteran, name war No
(c) Social Security No. No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 4
year 1942 hour 5 minute 15 a. m.

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 December 31 1941
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 31 1941 to February 4 1942
that I last saw her alive on February 4 1942
and that death occurred on the date and hour stated above.
Immediate cause of death Prematurity

8. AGE: Years Months Days If less than one day
1 4 hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name Dartwell Spence
13. Birthplace Quincy Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Halie Green
15. Birthplace Quincy Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2
17. (a) burial (b) Date thereof 2-15-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Reed St
18. (a) Signature of general director [Signature]
(b) Address City, Missouri
19. (a) 2/19/42 (b) M. M. Crowe
(Data received local registrar) (Registrar's signature)

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) Means of injury _____
23. Signature [Signature] (M. D. or other)
Address Gen Hospital-600 E. 42 Date signed 2-15-42

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.