

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2807

48
8308

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

1. PLACE OF DEATH: Jackson

(a) County: Kansas City

(b) City or town: Kansas City

(c) Name of hospital or institution: St. Vincent's Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 4 days

In this community 4 days

(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.: 3210 East 23rd St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Infant Schaefer

(b) If veteran, name war: XX

(c) Social Security No.: XX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July 23, day: 1942 Thursday

year: 1942 hour: 7:00 P.M. minute: M.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Sgl

6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: July 20, Monday 1942

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

8. AGE: Years: 0 Months: 0 Days: 3 1/4 Days hr. min.

Immediate cause of death: Asphyxia neonatorum

9. Birthplace: Kansas City, Missouri

(City, town, or county) (State or foreign country)

Due to: 1600

Due to:

10. Usual occupation: Infant

Other conditions: Subdural hemorrhage

(Include pregnancy within 3 months of death)

11. Industry or business:

MOTHER FATHER

12. Name: No Record

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

14. Maiden name: Charlene Schaefer

15. Birthplace: Madison, Missouri (City, town, or county) (State or foreign country)

Major findings: Of operations

Of autopsy: See above

PHYSICIAN: _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: St. Vincent's Hospital

(b) Address: 3210 E. 23rd St.

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?

17. (a) Burial (b) Date thereof: 7-24-42

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. St. Mary's Cemetery

18. (a) Signature of funeral director: J.M. Wagner

(b) Address: Kansas City, Mo.

19. (a) 7-24-42 (b) M. M. Brown

(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury: 0

23. Signature: Lorraine Sherwood (M. D. or other)

Address: St. Joseph Hosp. Date signed:

361

R.C.M.O.

MISSOURI
STATE BOARD OF
EMBALMERS

embalmed

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.

no
Embalmed

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.