

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 20 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3674

48
3
8

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:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 Days (Specify whether years, months or days)
In this community 2 Days

3. (a) PRINT FULL NAME Infant Haller
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Fe 5. Color or race Wh 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 Oct 3, 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Louis Haller
13. Birthplace Alma Kans,
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Howard
15. Birthplace Iola Kans.
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Haller
(b) Address 23 East 32 St. Terr

17. (a) Burial removed (b) Date thereof 10-7-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alma Kans

18. (a) Signature of funeral director [Signature]

(b) Address _____

19. (a) 10/6/42 (b) M. M. Crow
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 23 East 32 St. Terr.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5
year 42 hour 12 minute _____ P.M.

21. I hereby certify that I attended the deceased from 10-3 1942 to 10-5 1942
that I last saw her alive on 10-5 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital atelectasis
prematurity

Duration
birth
birth

Due to _____
Due to 159

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? _____

While at work? _____ (Specify type of place)
(g) Means of injury _____

23. Signature George H. [Signature] (M. D. or other)
Address 1107 Brought Bldg Date signed 10/6/42

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.....

2400 E. Jewell

Licensed Embalmer No.....

*3775
N. C. Mo*

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.