

FILED OCT 20 1942

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 3677

48  
833

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:  
O.K.C. General Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 50 minutes  
(Specify whether years, months or days)  
 In this community 50 min.  
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. 723 E. 13th  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Hopkins infant  
 3. (c) Social Security name war. no No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month June day 9th  
 year 1942 hour 5 minute 15 A.M.

4. Sex Female 5. Color or race W.  
 6. (a) Single, widowed, married, divorced S.  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased June 9th 1942  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-9-1942, 19\_\_\_\_, to 6-9-1942, 19\_\_\_\_, that I last saw her alive on 6-9-1942, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
				hr. <u>50</u> min.

Immediate cause of death  
Prematurity--malformation of nose; Hydrocephalus; bilateral club feet

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

Due to \_\_\_\_\_  
 Due to 157a

10. Usual occupation Infant  
 11. Industry or business \_\_\_\_\_  
 12. Name No record  
 13. Birthplace No record 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Betty Friend  
 15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

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.

16. (a) Informant Record Clerk  
 (b) Address K.C. General Hospital  
 17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Under  
 18. (a) Signature of funeral director Stan A. Johnson  
 (b) Address City  
 19. (a) 10-6-42 (b) M. M. Brown  
(Date 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?  
 23. Signature Dr. R. L. Johnson (Specify type of place) \_\_\_\_\_  
(M. D. or other)  
 Address Med. Dir. K.C. Gen. Hospital, K. (Specify means of injury) \_\_\_\_\_  
 Date signed \_\_\_\_\_

723 E. 13.

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**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.**