S. No. 2
DM—2-43
5-17-39
X35

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13298

FILED MAY 6 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1990

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. Gen. Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days)

In this community: all its life

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.: 4017 Baltimore (If rural, give location)

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

If yes, name country: x

3. (a) PRINT FULL NAME: Baby Glenda Arlene Mawhiney

3. (b) If veteran, name war: x

3. (c) Social Security No.: x

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: x

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

7. Birth date of deceased: March (Month) 12 (Day) 1943 (Year)

8. AGE: Years: - Months: 1 Days: 10 If less than one day: hr. min.

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

10. Usual occupation: x

11. Industry or business: x

MOTHER FATHER

12. Name: F. R. Mawhiney,

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

14. Maiden name: Shirley Arlene Lovelace,

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

16. (a) Informant: F. R. Mawhiney,

(b) Address: 4017 Baltimore, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-26-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park

18. (a) Signature of funeral director: Stine & McClure,

(b) Address: 3235 Gillham Plaza, K. C., Mo.

19. (a) 4-24-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 22nd year: 1943 hour: 6 minute: 15 P. M.

21. I hereby certify that I attended the deceased from 4-21-43, 19..., to 4-22-43, 19...; that I last saw her alive on 4-22-43, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
PYLORIC STENOSIS	
Due to 1579	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:

Of autopsy: See above

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? (Specify type of place)

While at work: (e) Means of injury:

23. Signature: Henry R. Thom (M. D. or other)

Address: Med. Dir. K. C. Gen. Hospital Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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.