

S. No. 2
DM-5-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13313
Registrar's No. 2019

FILED MAY 6 1943

Registration District No. 747

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
(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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1/2 Day (Specify whether years, months or days)
In this community 1/2 Day

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. 4221 Bellefontaine (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Infant MOHANNA

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced INFANT

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 4/26/43
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 9 hr. 05 min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Charles Mohanna

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

14. Maiden name Miss Martha Abraham

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

16. (a) Informant Charles Mohanna,
(b) Address 4221 Bellefontaine, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/43
(Month) (Day) (Year)

(c) Place: burial or cremation Burial at Calvary Cem.

18. (a) Signature of funeral director Melldy-McGilley
(b) Address K.C. Mo.

19. (a) 4/29/43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th
year 1943 hour 6:45 minute AM M.

21. I hereby certify that I attended the deceased from 4/26/43 to 4/27/43
that I last saw him 1m alive on 4/27/43 and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth at approximately 6 mo.

Due to 159

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence April 27, 1943

(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) (e) Means of injury _____
23. Signature Marie Edmond M.D. (M. D. or other) MD
Address 1300 Professional Bldg. Date signed 4-28-43

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.