

FILED JUN 7 1943
Registration District No. 149

Primary Registration District No. 1002

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: K. Gen. Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 few min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lewis infant
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Male 0 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 Feb. 10th 1943
(Month) (Day) (Year)

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

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

10. Usual occupation infant

11. Industry or business _____

12. Name Clenn Lewis

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

14. Maiden name Cecil Miles

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

16. (a) Informant Record clerk

(b) Address K. C. Gen. Hospital

17. (a) Burial (b) Date thereof 5-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Under

18. (a) Signature of funeral director Man a. Schuyler

(b) Address City Emporium

19. (a) 5-12-43 (b) Dr. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2926 Chelsea 8
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 10th
year 1943 hour 8:00 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from 2-10-43 to 2-10-43, 19____;
that I last saw him 1m alive on 2-10-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
Due to _____
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 _____
(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. M. Crowe (Specify type of place) _____
Address Med. Dir. K. C. Gen. Hospital (M, D, or other) _____
Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.