

FILED JUN 7 1948
Registration District No. 149

Primary Registration District No. 1002

2341

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 hrs. 30 min.
(Specify whether years, months or days) 9 hrs. 30 min.

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. 3419 Hardesty
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME INFANT SMITH

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

4. Sex Male 5. Color or race Negro 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. May 12, 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 hr. 30 min.

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

10. Usual occupation Infant

11. Industry or business.....
12. Name William Smith

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

14. Maiden name Ethel Ford

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

16. (a) Informant General Hospital #2
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof May 18 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Gardens Bras.

18. (a) Signature of funeral director Edmund Bras.
(b) Address 2000 E. 12th St. C. Mo.

19. (a) 5-21-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month March day 13, year 1943 hour 4 minute 45 AM

21. I hereby certify that I attended the deceased from 43 May 13 43 to May 13 43 that I last saw him alive on May 13 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Intra-cranial Hemorrhage Duration

Due to Micro-cephalic with hare-lip (Monstrosity)

Due to 1575

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) Means of injury.....

23. Signature J. O. Brown (M. D. or other) Address Gen. Hosp. #2 - 600 E. 22 Date signed 5-19-43

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

MOTHER FATHER

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. *