

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: **ST. LUKE'S HOSPITAL**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 hrs.**
(Specify whether years, months or days)

In this community **4 hrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **JACKSON**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")

(d) Street No. **436 W. 47th**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Baby Boy JANSEN**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **W**

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 **6-25-43**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **4 hr. 24 min.**

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **HARRY BERNARD JANSEN**

13. Birthplace **ST. LOUIS, MISSOURI**
(City, town, or county) (State or foreign country)

14. Maiden name **HELEN FRANCES SMITH**

15. Birthplace **BEDIAS, TEXAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. JANSEN (FATHER)**

(b) Address **436 W 47th ST.**

17. (a) **Cremation** (b) Date thereof **6 30 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. LUKE'S HOSP.**

18. (a) Signature of funeral director _____

(b) Address **H. C. D. My**

19. (a) **7-3-43** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **26**
year **1943** hour **11:30** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **11:29 A.M. 6-25-43** to **9:30 A.M. 6-26-43**
that I last saw him alive on **6-26-43**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Water Intoxication Due to Prematurity**

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: _____

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)

(e) Means of injury _____

23. Signature **D. E. Brown** (M. D. or other) _____

Address **1010 Professional Bldg** Date signed _____

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.