

SEP 7 1943

Registration District No. 149

Primary Registration District No. 1002

State File No.

Registrar's No.

3637

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Vincent's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 MRS
(Specify whether 7 MRS.)
In this community 7 MRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. 119 E. 79th St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Infant Huffard

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 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 8-16-43
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- - - 7 hr. 5 min.

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

10. Usual occupation infant

11. Industry or business

12. Name Harvey B. Huffard

13. Birthplace Platte Co., Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mildred T. Schanz

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

16. (a) Informant Norvel B. Huffard

(b) Address 119 E. 79th St. W. Mo.

17. (a) Burial (b) Date thereof Aug 25-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Second Creek - Sunbelt Mo.

18. (a) Signature of funeral director Norton F. Howard

(b) Address North Kansas City Mo

19. (a) 8-23-43 (b) J. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 16
year 43 hour 8 minute 05 PM

21. I hereby certify that I attended the deceased from Aug 16 43 to Aug 16 43
that I last saw him live on 8-16-43
and that death occurred on the date and hour stated above.

Immediate cause of death.....

atelectasis

Due to Prematurity

Due to 159

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy no

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 0

23. Signature Calvin A. Beard (M. D. or other)
Address 2307 P. Ryan Bldg Date signed 8-20-43

Duration

7 Hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

John J. Morton

Licensed Embalmer No. *4349*

P. O. Address *None*

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.