

FILED SEP 28 1943

State File No. _____
Registrar's No. 3925

Registration District No. _____

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 Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME

Infant Dixie

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

Sept 12 - 1943
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

0

0

0

13 hr.

1 min.

9. Birthplace

Trinity Lutheran Hosp. Mo.
(City, town, or county) (State or foreign country)

Mo.
(State or foreign country)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

Tom Hlice

13. Birthplace

DeKal County, Missouri
(City, town, or county) (State or foreign country)

Missouri
(State or foreign country)

14. Maiden name

Dolly King

15. Birthplace

St. Louis, Missouri
(City, town, or county) (State or foreign country)

Missouri
(State or foreign country)

16. (a) Informant

Trinity Lutheran Hosp

(b) Address

1500 Mo

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9-13-43
(Month) (Day) (Year)

(c) Place: burial or cremation

2nd Ave. Hill

18. (a) Signature of funeral director

J. E. Brown

(b) Address

1500 Mo

19. (a) Date received local registrar

9-13-43
(Date received local registrar)

(b)

J. E. Brown
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Jackson City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1041 E 1st
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9/12 day 12 year 1943 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from 9 12 1943 to 9/12 1943 that I last saw him alive on Sept 12 1943 and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchocarcin

Due to

malformation (Congenital) 157MA

Due to

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) L
(b) Date of occurrence L
(c) Where did injury occur? L
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? L

(Specify type of place)

(e) Means of injury

23. Signature H. H. Lane (M. D. or other)

Address 824 Beale Date signed 9/13/43

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 *Allen D. Leggett*

Licensed Embalmer No. *4223*

P. O. Address *PK 110*

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.