

Registration District No. **1002/49**

Primary Registration District No. **1002**

Registrar's No. **4159**

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 No. 2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**  
(Specify whether years, months or days)

In this community **3 months**

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. **1110 Euclid**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **DELORES MARIE OLIVER**

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

4. Sex **Female** 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 **June 3, 1943**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>3</b>	<b>21</b>		hr. 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 **Harold L. Oliver**

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

14. Maiden name **Morlene Vaughn**

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

16. (a) Informant **Record Clerk**  
(b) Address **General Hospital No. 2**

17. (a) **Burial** (b) Date thereof **9-28-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Winceln**

18. (a) Signature of funeral director **Adkins Bros.**

(b) Address **20002, 12th St. C. Mo**

19. (a) **9-30-43** (b) **N. E. Brown**  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9-24-43** day \_\_\_\_\_ year \_\_\_\_\_ hour **1** minute **40** A. M.

21. I hereby certify that I attended the deceased from **9-22-43**, 19\_\_\_\_, to **9-24-43**, 19\_\_\_\_, that I last saw her alive on **Sept. 24, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Malnutrition**

Due to \_\_\_\_\_  
Due to **158**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature **[Signature]** (M. D. or other) **[Signature]**  
Address **General Hosp # 2** Date signed **[Signature]**

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

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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.....

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.**