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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33726

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4242

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: K. C. General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
In this community 12 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 409 Penn. 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) J
If yes, name country

3. (a) PRINT FULL NAME Carpenter Infant
3. (b) If veteran, name war no
3. (c) Social Security No. none
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 9-16-43 (Month) (Day) (Year)
8. AGE: Years | Months | Days 12 | If less than one day hr. min.
9. Birthplace K-C. (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation infant
11. Industry or business
12. FATHER Name Thomas Carpenter
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)
14. MOTHER Maiden name Mary Brown
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant Record Clerk
(b) Address K C Health Dept
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-4-43 (Month) (Day) (Year)
(c) Place: burial or cremation Lawn
18. (a) Signature of funeral director Wm A Johnson
(b) Address City Mortician
19. (a) 10-6-43 (Date received local registrar) (b) N. E. Brown Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28th year 1943 hour 9 minute 10 A.M.
21. I hereby certify that I attended the deceased from Sept. 16th 1943 to Sept. 28th 1943 that I last saw him alive on Sept. 28th 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Malnutrition	
Due to 15	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dwey R. Thom (M. D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 9-29-43

(Licensed Embalmer's Statement on Reverse Side)

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.