

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **Jackson**  
(a) County **Kansas City Kaw Twp**  
(b) City or town **Kansas City Kaw Twp**  
(c) Name of hospital or institution: **St Vincents Hospital**  
(d) Length of stay: In hospital or institution **18 hrs**  
In this community **18 hrs**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **3311 East 22nd St**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Infant of Howard Shoaf**

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 **Oct 20th 1943**

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day **18 hr. min.**

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

10. Usual occupation **infant**

11. Industry or business \_\_\_\_\_

12. Name **Howard Shoaf**

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

14. Maiden name **Barbara Spader**

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

16. (a) Informant **Howard Shoaf**

(b) Address **3311 E. 22nd St**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct 22, 43** (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Earp Funeral Home**

(b) Address **4139 E. 15th Kansas City Mo**

19. (a) **10-22-43** (Date received local registrar) (b) **J. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **21** year **1943** hour **6** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **1943** to **1943**

That I last saw him **alive** on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Impression of death **Patent foramen ovale (Congenital heart disease)**

Due to \_\_\_\_\_

Due to **157e**

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

Major findings: **Of operations**

Of autopsy **See above**

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 **C. E. Brown** (M. or other) **3** Date signed **10/23/43**

Address \_\_\_\_\_

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

MOTHER FATHER

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.....

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.**