S. No. 2
M—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1943

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 37332

Registrar's No. 4573

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: Conley Clinical Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 hr (Specify whether
In this community 1 hr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48 3

(c) City or town K. C. 8
(If outside city or town limits, write "RURAL")

(d) Street No. 4617 E. 37th. St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Infant Jensen

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male

5. Color or race white 0

6. (a) Single, widowed, married, divorced Infant 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 20, 1943
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 1 hr. 20 min.

9. Birthplace Kansas City, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Frank Marvin Jensen
13. Birthplace Kansas City, Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Betty Lee Coggins
15. Birthplace Kansas City, Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Betty Jensen
(b) Address 4617 East 37th St.

17. (a) retained at Hosp. (b) Date thereof 10-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Retained for anatomic speciman at Conley Clinical Hospital

18. (a) Signature of funeral director
(b) Address K. C. Mo.

19. (a) 10-28-43 (b) D. E. Brown Dep
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20
year 1943 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from birth 10/20/43, 19 to expiration 19;
that I last saw him alive on 10/20/43, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital malformation of respiratory and genito urinary tracts.

Due to not known

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Rudimentary lungs, displaced kidneys, cystic thymus gland.

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? (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 A. H. Cockerell, Dr. (M.D. or other)

Address 2105 Indep. Ave. Date signed 10-26-43

(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.