

FILED FEB 8 1944

Registration District No. **1002**

Primary Registration District No. **1002**

Registrar's No. **5727**

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 No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
In this community **1 Mos**
(Specify whether years, months or days)

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. **4321 Marshall Rd**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Byron Blevins**

3. (b) If veteran, name war **unk** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Male** 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 **November 11 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 10 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **unknown**

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

14. Maiden name **unknown**

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

16. (a) Informant **Record Clerk**

(b) Address **Kansas City General Hosp. #**

17. (a) **Cremation** (b) Date thereof **2-4-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. C. Ave. Hosp.**

18. (a) Signature of funeral director **John A. Thompson**

(b) Address **City**

19. (a) **2-31-43** (b) **J. B. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **23**
year **1943** hour **3** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **December 21 1943** to **December 23 1943**
that I last saw him alive on **December 23 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Epidemic Diarrhea**
pending further investigation

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) **11 ad**

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)

Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) Means of injury _____

23. Signature **Dr. R. Thorn** (M. D. or other) _____

Address **Med. Dir. Gen'l Hosp** Date signed **12-24-43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 149

Primary Registration District No. 1002

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Byron Bleunis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color (white) 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased nov 1 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Swilbur, Scott
13. Birthplace Yates Center, Ks
(City, town, or county) (State or foreign country)
14. Maiden name Lillian (Loving)
15. Birthplace Yates Center, Ks
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) (Signature)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month dec day 3
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____

that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to dehydration

Due to acute Gastro-

Other conditions Enteritis
(Include pregnancy within 3 months of death)

Major findings: non-specific
Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

PLEASE PRINT IN UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

