

Registration District No. 149

Primary Registration District No. 1002

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

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: Fairmount Maternity  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13 hrs. (Specify whether  
 In this community 13 hrs.  
 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. 1414 East 27th St.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country —

3. (a) PRINT FULL NAME Karen Kinnick

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex Female 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 February 4 1944  
 (Month) (Day) (Year)

8. AGE: Years — Months — Days 13 hr. — min. If less than one day

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

10. Usual occupation None

11. Industry or business —

MOTHER FATHER { 12. Name James Townsend  
 13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)  
 14. Maiden name Lucille Kinnick  
 15. Birthplace Indianapolis Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Fairmount Hospital  
 (b) Address 1414 East 27th St. K.C., Mo.

17. (a) Burial (b) Date thereof 2/9/44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery, K.C. Mo.

18. (a) Signature of funeral director H. C. Brown  
 (b) Address 1415 East 15th Kansas City, Mo.

19. (a) 2-5-44 (b) H. C. Brown  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5th year 1944 hour 5:00 minute — A.M.

21. I hereby certify that I attended the deceased from February 4th, 1944, to February 5th, 1944, that I last saw h.e.t. alive on February 4, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity  
10th month delivery

Due to —  
 Due to —

Other conditions none  
 (Include pregnancy within 3 months of death)

Major findings: Of operations —  
 Of autopsy — 159

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) No  
 (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 Gredt Kyger (M. D. or other) MD  
 Address 610 Prof Bldg Date signed Feb 5 1944

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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.**