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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6347

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 778

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Lukes Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)
In this community 6 days

2. USUAL RESIDENCE OF DECEASED: 54
(a) State Mo (b) County Lexington mo 3
(c) City or town (If outside city or town limits, write "RURAL") 2
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3. (a) PRINT FULL NAME Infant — Mr. + Mrs. Eugene Storey
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 Feb (Month) 9 (Day) 1944 (Year)

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace St. Luke's Hospital Kansas City Mo (City, town, or county) (State or foreign country)
10. Usual occupation infant
11. Industry or business
MOTHER FATHER
12. Name Eugene M. Storey
13. Birthplace (City, town, or county) mo (State or foreign country)
14. Maiden name Opal Hawkins
15. Birthplace (City, town, or county) Ind (State or foreign country)
16. (a) Informant Eugene M Storey
(b) Address Lexington mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 16 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Pittsburg Kans
18. (a) Signature of funeral director Mrs C. C. Foster
(b) Address 714 Brooklyn
19. (a) 2-16-44 (Date received local registrar) (b) M. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1944 hour : minute a M.
21. I hereby certify that I attended the deceased from 2-11, 1944, to 2-15, 1944 that I last saw him alive on 2-14, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: aspiration pneumonia	2 days
Due to: Congenital anomaly Esophagus (Probably Tracheo-esophageal fistula)	birth
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

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

23. Signature Geo V Herrman (M. D. or other)
Address 1107 Bryant Bldg Date signed 2/15/44

(Licensed Embalmer's Statement on Reverse Side) K.C. 6 Mo

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.