

FILED APR 6 1949

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **1291**

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: **Lake side Hospital.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 M. 10 min.**
(Specify whether)

In this community **2 Hours 10 minutes**
years, months, or days

3. (a) PRINT FULL NAME: **Floyd E. Trotter (Baby) Trotter.**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no.**

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 **March 22 44**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			2 hr. 10 min.

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

10. Usual occupation **infant**

11. Industry or business _____

MOTHER FATHER

12. Name **Floyd Ereneth Trotter**

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

14. Maiden name **Mary Gene Mayfield**

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

16. (a) Informant **Floyd E. Trotter**

(b) Address **701 Brooklyn**

17. (a) **Removal** (b) Date thereof **Mar-22-1949**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Waverly, Mo. Wm. C. Foraker**

18. (a) Signature of funeral director **Wm. C. Foraker**

(b) Address **718 Brooklyn**

19. (a) **3-22-49** (b) **D. E. Brown**
(Date received local registrar) (Registrar's signature)

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. **701 Brooklyn**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **22**
year **1944** hour _____ minute **5:33** M.

21. I hereby certify that I attended the deceased from **2:26 AM**
_____ 19____ to **5:35 AM** 19____

that I last saw him alive on **3/22**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

Duration _____

Due to _____

Due to _____

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

Major findings: **159**

Of operations _____

Of autopsy **None**

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? _____ (c) Means of injury _____

23. Signature **Dr. Wm. A. Jager** (M. D. or other) **W.A.J.**

Address **303 E. Harrison** Date signed **3/22/49**

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

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.