

FILED MAY 5 1944
Registration District No. 749

Primary Registration District No. 1002

Registrar's No.

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:
St. Lukes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 510 W. 10th
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country U.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1944 hour 4 minute P.M.
21* I hereby certify that I attended the deceased from 4-26
1944 to 4-30 1944.
that I last saw h. alive on
and that death occurred on the date and hour stated above.

Immediate cause of death:
Post mortem 4-30-44
1. Aspiration tracheopneumonia
Due to 2. Congenital atresia of
esophagus with
Due to tracheo-esophageal
fistula
Other conditions:
3. Passive congestion
(Include pregnancy within 3 months of death)
of the viscera

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations 1
Of autopsy 157g

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 J. H. Ashkin M.D. (M. D. or other)
Address St. Luke Hospital Date signed 4-30-44

3. (a) PRINT FULL NAME MARY MONZELL Mc DONALD

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

7. Birth date of deceased: April 26 1944
(Month) (Day) (Year)

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

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

10. Usual occupation infant

11. Industry or business

12. Name Harry Winston Mc Donald

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

14. Maiden name Marquette Cleo Halberner

15. Birthplace Hale Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Monzell Halberner

(b) Address 510 W. 10th Kansas City, Mo.

17. (a) Burial (b) Date thereof May 11, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale cemetery

18. (a) Signature of funeral director Mont E. Stetson

(b) Address Hale Mo.

19. (a) 4-30-44 (b) M. E. Brown
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Patrol
....., Registered Apprentice No.
working under my personal supervision.

Signed Frank E. Slater
Licensed Embalmer No. 927
P. O. Address State Mo.

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.