

No. 2
8-43
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DEPARTMENT OF COMMERCE

BUREAU OF VITAL STATISTICS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16950
Registrar's No. 2015

FILED MAY 23 1944

Registration District No. 149

Primary Registration District No. 1002

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. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 15 months
years, months or days (Specify whether)

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. 2307 Quincy
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Patricia Cantrall

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 January 23, 1943
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Bruce Cantrall

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

14. Maiden name June Laymon

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

16. (a) Informant Mrs June Cantrall

(b) Address 2307 Quincy

17. (a) Burial (b) Date thereof 5/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem

18. (a) Signature of funeral director Durbin & Palmer Co

(b) Address 20 West Linwood Blvd.

19. (a) 5-9-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1944 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 6, 1944 to May 8, 1944
that I last saw her alive on May 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia- Measles Duration _____

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy See above

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 A. E. Thayer (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 5-8-44

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.....
....., 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.