

S. No. 2  
DM-5-42  
v. 5-17-39  
-1 X32873

23767

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED AUG 14 1944

3148

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. ....

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 HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 1/2 hrs.  
(Specify whether 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 E 27  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME BETTY JANE JONES

3. (b) If veteran, name war X MD  
3. (c) Social Security No. X none

4. Sex FEMALE 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased JULY 27 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 0 5 hr. 30 min.

9. Birthplace KANSAS CITY MO  
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business X

12. Name GASTON TAYLOR  
13. Birthplace UNKNOWN (State or foreign country)  
14. Maiden name ALICE JONES  
15. Birthplace HOPKINSVILLE KY  
(City, town, or county) (State or foreign country)

16. (a) Informant FAIRMOUNT HOSPITAL  
(b) Address 1414 E 27

17. (a) Burial (b) Date thereof 8-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn  
18. (a) Signature of funeral director A. B. Dochler  
(b) Address 1415 E 15

19. (a) 8-1-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 27  
year 1944 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from JULY 27  
1944, to JULY 27, 1944;  
that I last saw her alive on JULY 27, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth  
Twins  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 0  
23. Signature Fred B. Nyger (M. D. or other) \_\_\_\_\_  
Address 510 Prof. Bldg Date signed 7-28-44

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

MOTHER FATHER

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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.**