

V. S. No. 2
00M-5-43
Rev. 5-17-39
I X36671

FILED JAN 11 1945
Registration District No. 1945

Primary Registration District No. 1002

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

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:
General Hospital #2
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 11-23-44-11-24-44
(Specify whether) 1 day

In this community 1 day
years, months or days)

3. (a) PRINT FULL NAME INFANT DIXON

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

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 November 23 1944
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>1</u>	<u>7</u> hr. <u>30</u> min.

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

10. Usual occupation Unemployed

11. Industry or business infant

12. Name _____

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

14. Maiden name Alice Dixon
(City, town, or county) (State or foreign country)

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Cremation (b) Date thereof 12-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 1st E. Gen. Hosp.

18. (a) Signature of funeral director Wm. A. Bohmeyer

(b) Address City Mortician

19. (a) 12-28-44 (b) W. 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. 1311 Lydia
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24
year 1944 hour 12:30 minute _____ p. _____ M.

21. I hereby certify that I attended the deceased from November 23
19 44 to November 24 1944;

that I last saw h im alive on November 24 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

Other conditions 15-9
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place)

Means of injury 0

23. Signature W. E. Brown (M. D. or other)

Address Gen. Hosp. #2, 600 E. 22nd Date signed 11-28

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.