

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40325
5316
Registrar's No. _____

FILED JAN 11 1945

Registration District No. 149

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:
Gen. Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Hr. 10 Min. 4-28-44
(Specify whether
In this community 1 Hr. 10 Min.
years, months or days)

3. (a) PRINT FULL NAME INFANT REVELS
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 April 28 1944
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | | | | <u>1 hr. 10 min.</u> |

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name LeRoy Revels
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Lampkins
15. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2

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

(c) Place: burial or cremation M. E. Burial Home

18. (a) Signature of funeral director M. E. Burial Home
(b) Address City Medication

19. (a) 12-28-44 (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. 1603 Forest
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1944 hour 3:40 minute P. M.

21. I hereby certify that I attended the deceased from 2:30 P.M. April 28
April 28 19 44 to 3:40 P.M. April 28 19 44;
that I last saw him alive on April 28 19 44;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant

Due to _____
Due to _____

Other conditions 159
(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 _____

Where did injury occur? _____ (City or town) (County) (State)
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 _____

23. Signature [Signature] (For other) _____
Address Gen. Hosp. 12 600 E. 22nd. Date signed 5-1-44

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.