

FILED FEB 6 1945
799

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 381

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. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 51 mins.
(Specify whether years, months or days)
In this community 0 51 mins.

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. 4504 Virginia
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clark Infant

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 Jan. 10 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 51 min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name Claude Clark
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Elsie Barnett
15. Birthplace Ark. / (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K. C. Gen'l Hosp. No. 1

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 1-10-45
(Month) (Day) (Year)
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Don A. Stuyver
(b) Address City, Missouri

19. (a) 1-24-45 (Date received local registrar) H. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10
year 1945 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan. 10 45 to Jan. 10 45
that I last saw her alive on Jan. 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Premature

Due to _____

Due to _____

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

Major findings: Of operations _____
Of autopsy None

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 A. E. Upsher (M. D. or _____)
Address Med. Dir. Gen'l Hosp. Date signed 1-10-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed *Wm A. Schaeffer*.....

Licensed Embalmer No. *3089*.....

P. O. Address *KC 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.