

FILED JAN 17 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:
3022 Mercier - 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify in detail)
In this community 3 days
(Specify in detail)
years, months or days

3. (a) PRINT FULL NAME Infant McNeal

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

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 31 1944
(Month) (Day) (Year)

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

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

10. Usual occupation none

11. Industry or business _____

12. Name Dra. McNealy

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

14. Maiden name Dorthea

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

16. (a) Informant Mrs Dorthea McNeal

(b) Address 3022 Mercier

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-45
(Month) (Day) (Year)

(c) Place: burial or cremation Lingula Cemetery

18. (a) Signature of funeral director H. B. Moore

(b) Address 1820 East 18 st

19. (a) 1-3-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3022 Mercier St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 2
year 1945 hour 4 am M.

21. I hereby certify that I attended the deceased from 12-31-44 to 1-25-45, 1945
that I last saw him alive on 1-1-45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death unofficial hemorrhage from umbilical
Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy no

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) (e) Means of injury 0

23. Signature D. E. Brown (M. D. or other) _____
Address 2700 E 18 Date signed 1-2-45

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 me

HB Mason, Registered Apprentice No. _____
working under my personal supervision.

Signed HB Mason

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 st

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.