

FILED JAN 17 1945
 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. **5421**

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: Research Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 hr 40 min (Specify whether years, months or days)
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. 717 W 44th Street **7**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ **A**

3. (a) PRINT FULL NAME Baby Boy O'Neal
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex MALE 5. Color or race W
 6. (a) Single, widowed, married, divorced single
 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years _____ Months _____ Days _____
 If less than one day 6 hr 40 min

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Milton Thomas O'Neal

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

14. Maiden name MARY A. RET. AMANDA HALSTEAD

15. Birthplace KANSAS CITY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Milton O'Neal

(b) Address 717 W 44th St Kansas

17. (a) Cremation (b) Date thereof 12-31-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hospital

18. (a) Signature of funeral director _____
 (b) Address H. C. no.

19. (a) 12-31-44 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 30
 year 1944 hour 5:30 PM (Specify AM or PM) M.
 21. I hereby certify that I attended the deceased from Dec 30
 1944, to Dec 30 1944
 that I last saw h.i.m. alive on December 30 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death 6mo. premature
 Due to Rupture of membranes
 Due to _____
 Other conditions 15-9
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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? _____ Means of injury no
 23. Signature Don Barber Gurry (M. D. or other) MD
 Address 717 Prof. Bldg Date signed 1/6/45

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

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.