

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 TRINITY LUTHERAN HOSPITAL
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 15 hr 3 min
(Specify whether)
 In this community same
years, months or days

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. 4621 Genessee
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME David La Doucieur

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 0

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

7. Birth date of deceased: 2-13-45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 15 hr. 3 min.

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

10. Usual occupation new born

11. Industry or business _____

12. Name Bennie L. La Doucieur

13. Birthplace Roulette North Dakota
(City, town, or county) (State or foreign country)

14. Maiden name Ruth K. McGuire

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

16. (a) Informant father

(b) Address 4621 Genessee K.C. Mo.

17. (a) Removal (b) Date thereof 2-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Butler Mo.

(d) Signature of funeral director Butler Funeral Home

(e) Address Butler Mo.

19. (a) 2-14-45 (b) _____ (c) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14
 year 1945 hour 3 minute 47 A. M.

21. I hereby certify that I attended the deceased from 12:44 AM
2-13-45, 1945, to 2 AM 2-14, 1945,
 that I last saw him alive on Feb 14, 1945,
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Premature twin

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 _____

(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)

(e) Means of injury 0

23. Signature Geo J. [unclear] (M. D. or other) MD

Address 932 Poy Bldg Date signed _____

Duration
10:7 1/2
700

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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.