

FILED MAR 15 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 5568

Registrar's No. 45

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Fairmount Sta. Kansas City, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Blue Jump  
211 South Cedar  
(If not in hospital or institution, give street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 27 Day's  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Fairmount Sta. Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 211 South Cedar  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DONNA KAY LAQUET

3. (b) If veteran, name war None 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. 18 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 27 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Russell LaQuet

13. Birthplace O'Fallon Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Clayds Barker

15. Birthplace Rock Lake no Dokato  
(City, town, or county) (State or foreign country)

16. (a) Informant Russell LaQuet

(b) Address 211 So Cedar, K.C. Mo.

17. (a) Burial (b) Date thereof 2 15 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Zion

18. (a) Signature of funeral director Geo C. Carson

(b) Address Independence, Missouri

19. (a) 2-15-45 (b) James W. Ross  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14  
year 1945 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from  
Jan 18 1945 to Feb 14 1945  
that I last saw her alive on Feb 13 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Prematurely (Twin)  
Due to Insanitation

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 159

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature George W. Paul (M. D. or other)

Address 1103 1/2 Ulm Rd. Sny Date signed 2-15-45

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

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1163

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

*Walter C. Larson*  
Licensed Embalmer No. *H 199*

P. O. Address *Indiantown*

**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.**