

**FILED MAR 24 1945**

Registration District No. **179**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME Infant DRZANEK

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

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

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

7. Birth date of deceased March 6th 1945  
(Month) (Day) (Year)

8. AGE: Years 000 Months 000 Days 1 If less than one day hr. --- min. ---

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

10. Usual occupation Infant

11. Industry or business Baby

12. Name John Drzanek

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

14. Maiden name Evelyn Chisolm

15. Birthplace Newport News Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant John Drzanek

(b) Address 7622 Bellevue

17. (a) Burial (b) Date thereof 3-8-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Melody McGilley

(b) Address Kansas City Missouri

19. (a) 3-7-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7622 Bellevue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th  
year 1945 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from Pathologist, 19...;  
that I last saw him alive on -----, 19...;  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity  
Atelectasis (pulmonary)

Other conditions 15-4  
(Include pregnancy within 5 months of death)

Major findings: Of operations -----  
Of autopsy As above

PHYSICIAN

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? -----

While at work? (Specify type of place) (e) Means of injury -----

23. Signature bruce Shumard (M.D. number) -----  
Address Pathologist Date signed 3-7-45

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

80000

**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 Russell W. France  
Licensed Embalmer No. 4255  
P. O. Address K.C. 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.**