

FILED APR 17 1945
149

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1412

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: General Hospital #2
(If not in hospital or institution, write street number or locality)
(d) Length of stay: In hospital or institution 3 days
In this community 3 days
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. 1629 Benton
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SHIRLEY ANN SCOTT

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

4. Sex Female 5. Color or race Negro 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 March 19 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 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 _____

12. Name Charley William Scott

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

14. Maiden name Zora Lee Pace

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

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 3-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln
18. (a) Signature of funeral director Adkins Pres
(b) Address 2000 E. 12th Rv. Mo

19. (a) 3-27-45 (b) H. Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1945 hour 10:30 minute 4 M.

21. I hereby certify that I attended the deceased from March 19 1945 to March 22 1945; that I last saw him or alive on March 22 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Umbical Hernia (post-operative)

Due to _____

Due to _____

Other conditions (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? _____

While at work? _____ (Specify type of work) (Specify means of injury)

23. Signature S. Holmes (M. D. or other) _____
Address Gen. Hosp. #2 - 600 E. 22 Date signed 3-27-45

Duration

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 A. T. Moore.....

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.