. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 20 1945

State File No. 29891

Registrar's No. 3723

Registration District No. 149 Primary Registration District No. 1002

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: FAIRMOUNT HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 4 HRS. (Specify whether years, months or days)

In this community: 4 HRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON 46

(c) City or town: KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 1414 E 27 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: SIDNEY SHANKS

3. (b) If veteran, name war: X

3. (c) Social Security No.: X

4. Sex: MALE 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: S 0

6. (b) Name of husband or wife: X

6. (c) Age of husband or wife if alive: X years

7. Birth date of deceased: SEPT. (Month) 5 (Day) 1945 (Year)

8. AGE: Years ✓ Months ✓ Days ✓ If less than one day: 4 hr. min.

9. Birthplace: KANSAS CITY (City, town, or county) MO (State or foreign country) 11

10. Usual occupation: X

11. Industry or business: X

MOTHER FATHER

12. Name: JOHN BELLIEU

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

14. Maiden name: EDWINA SHANKS

15. Birthplace: HOWARD (City, town, or county) KANS. (State or foreign country)

16. (a) Informant: FAIRMOUNT HOSPITAL

(b) Address: 1414 E 27

17. (a) Burial (Burial, cremation, removal) (b) Date thereof: Sept. 7-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Green Lawn

18. (a) Signature of funeral director: A. P. Doehler

(b) Address: 1415 E 15

19. (a) 9-7-45 (Date received local registrar) Geraldine Helmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: SEPT day: 5 year: 1945 hour: 8 minute: 55 A.M.

21. I hereby certify that I attended the deceased from SEPT 5, 1945, to SEPT 5, 1945; that I last saw him alive on SEPT 5, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Premature Birth	
Due to: unknown causes,	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 159	

Major findings:
Of operations:

Of autopsy:

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? (Specify type of place)

While at work?

(e) Means of injury: 0

23. Signature: Fred B Hyger (M. D. or other) M. D.

Address: Professional Bldg. Date signed: Sept. 6-45

(Licensed Embalmer's Statement on Reverse Side)

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.