S. No. 2
M—5-43
. 5-17-39
. 1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32878

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4273

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

(d) Length of stay: In hospital or institution: 36 hours (Specify whether years, months or days)
In this community: 36 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

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

(d) Street No.: ~~General Hospital~~ 8
(If rural give location) 2900 Mercier 0

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Rounds Infant

3. (b) If veteran, name war: no

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: August 3, 1945 (Month) (Day) (Year)

8. AGE: Years | Months | Days: 1½ | If less than one day: hr. min.

9. Birthplace: Kansas City (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation: infant

11. Industry or business:

FATHER
12. Name: Clarence Albert Rounds
13. Birthplace: Normal, Ill. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name: Hazel Worths
15. Birthplace: St. Joseph, Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant: R. R. L.
(b) Address: K. C. General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Linde

18. (a) Signature of funeral director: Wm. A. Lobmeyer
(b) Address: City Mortician

19. (a) 10-17-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 4
year: 1945 hour: 7 minute: 32 P.M.

21. I hereby certify that I attended the deceased from August 3, 1945 August 4, 1945
that I last saw her alive on August 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
congenital heart	
multiple other anomalies	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 1572	

Major findings:
Of operations:
Of autopsy: See 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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: Clark W. Lieberman M.D. (M.D. or other)
Address: Med. Dir. K.C. General Hospital Date signed

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm A Lohmeyer

Licensed Embalmer No. 3089

P. O. Address KC 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.