

FILED NOV 26 1945

Registration District No. 177

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson County

(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:
General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 7 hr - 45 min
(Specify whether years, months or days)

In this community Same 7 hr - 45 min
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Infant Hellsman

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

3. (c) Social Security No. none

4. Sex Female 3

5. Color or race Negro

6. (a) Single widowed, married, divorced Infant 1

6. (b) Name of husband or wife

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

7. Birth date of deceased. 11 4 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>7</u> hr. <u>45</u> min.

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

10. Usual occupation infant

11. Industry or business

12. Name X

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

14. Maiden name Rosa Mae Hellsman

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of funeral director Wm A. ...

(b) Address City ...

19. (a) 11-14-49 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson County

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

(d) Street No. 1612 Lydia
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4
 year 1945 hour 11 minute A.M.

21. I hereby certify that I attended the deceased from 3:55 A.M.
11:00 A.M., 19 , to , 19 ;

that I last saw her alive on 11-4-45, 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis,
Premature Infant

Due to

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) (b) Means of injury

23. Signature [Signature] (M. D. or other)

Address Gen. Hosp. #2-600 E. 22nd Date signed 11-5-45

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. Schmeyer*.....

Licensed Embalmer No. *3089*.....

P. O. Address *110 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.