S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

36274

State File No.

FILED NOV 26 1945

Registration District No. 44 Primary Registration District No. 1002 Registrar's No. 4713

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:
Conley Maternity Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 hrs (Specify whether
In this community 21 hrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1246 Lawndale 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Baby McClain

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 1

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 Oct. (Month) 27 (Day) 1945 (Year)

8. AGE: Years | Months | Days | If less than one day 20 hr. 56 min.

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

10. Usual occupation infant

11. Industry or business

MOTHER FATHER

12. Name Claude McClain

13. Birthplace Independence (City, town, or county) Missouri 0 (State or foreign country)

14. Maiden name Berneice Ione Roberts

15. Birthplace Olden Hill (City, town, or county) Kansas 1 (State or foreign country)

16. (a) Informant Berneice Roberts McClain
(b) Address 1246 Lawndale

17. (a) Retained at Conley Hospital for Anatomic study (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year) 11-15-45
(c) Place: burial or cremation Conley Hosp

18. (a) Signature of funeral director Conley Hosp
(b) Address K. C. Mo

19. (a) 11-15-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28 year 1945 hour 2:00 minute A M.

21. I hereby certify that I attended the deceased from 10-27 1945 to 10-28 1945 that I last saw him or alive on October 28 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Premature Birth
Due to Causes unknown
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?
While at work (Specify type of place) (e) Means of injury

23. Signature Arthur W. Swift (M. D. or other) MD
Address 2105 Indep. Ave. 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.....

....., 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.