

FILED DEC 21 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No.

4966

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 location)
(d) Length of stay: In hospital or institution 1 day 4 hrs.
(Specify whether years, months or days)
In this community 1 day 4 hrs.

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. 2530 Brooklyn
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ceasar, Infant

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 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 November 20, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day 4 hr. 21 min.

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

10. Usual occupation None

11. Industry or business _____

12. Name _____

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

14. Maiden name Lillie Belle Ceasar

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof Dec 4 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director West. Appl. Mort. Serv.

(b) Address _____

19. (a) 12-3-45 (b) Thelma Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 21,
year 1945 hour 1 minute 10 P.M.

21. I hereby certify that I attended the deceased from November 20,
19 45, to November 21, 19 45
that I last saw him alive on November 21, 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Obstruction Duration 1 day

Due to Cause Undetermined

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 158
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 place)
Means of injury _____

23. Signature [Signature] (M. D. or other)
Address General Hospital #2

Date signed 11/23/45

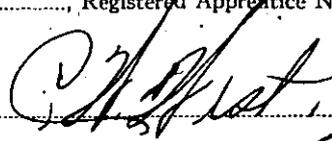
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....



Licensed Embalmer No. 2710.....

P. O. Address. W. C. M. O.....

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.