

FILED DEC 28 1945

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: Research Hospital  
(d) Length of stay: In hospital or institution 8 hr 35'  
In this community 8 hr 35'

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. Jackson (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 5015 Paseo  
(e) Citizen of foreign country? no.

3. (a) PRINT FULL NAME Baby Grant  
(b) If veteran, name war no (c) Social Security No. none

4. Sex female 5. Color or race w 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive, years .....

7. Birth date of deceased Nov. 24, 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
8 hr 35 min

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

10. Usual occupation infant

11. Industry or business .....  
12. Name Lafayette Crum Grant  
13. Birthplace Deepwater Missouri  
14. Maiden name Betsy Ann Sawyer  
15. Birthplace Kansas City Missouri

16. (a) Informant Mrs Betsy Grant  
(b) Address 5015 Paseo

17. (a) Cremation (b) Date thereof Nov 25, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hospital  
18. (a) Signature of funeral director Research Hosp  
(b) Address R-C. Mo

19. (a) 12-10-45 (b) S. Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 24  
year 1945 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from Nov. 24, 1945 to Nov. 24, 1945  
that I last saw h.e.r. alive on Nov. 24, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Sepsis of meningococcus  
Rupture of meningococcus

Due to .....  
Due to .....  
Other conditions (Include pregnancy within 3 months of death) 157a

Major findings: Of operations .....  
Of autopsy as above

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 0  
23. Signature Don Baker Esq. M.D. (M. D. or other) .....  
Address 707 Pr. Bldg Date signed 12/1/45

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

MOTHER FATHER

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**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.**