

FILED JUL 12 1946
Registration District No. _____

Primary Registration District No. **1002**

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

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 No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 hrs. 40 min.**
(Specify whether)
 In this community **10 hrs. 40 min.**
years, months or days

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

4. Sex **Male**
 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **Single**
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **June 6, 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 hr. 40 min.

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

10. Usual occupation **infant**

11. Industry or business _____

MOTHER FATHER {
 12. Name **Hubert E. Slater**
 13. Birthplace **Texas**
(City, town, or county) (State or foreign country)
 14. Maiden name **Martha Greene**
 15. Birthplace **Independence, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
 (b) Address **General Hospital No. 1**

17. (a) **Burial** (b) Date thereof **6-24-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Lead 3**

18. (a) Signature of registrar **Tom A. Johnson**
 (b) Address **City, Missouri**

19. (a) **6-20-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

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. **209 W. 16 St.**
(If rural, give location)
 (e) Citizen of foreign country? **no.** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **7**
 year **1946** hour **5** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **June 6, 1946** to **June 7, 1946**
 that I last saw him alive on **June 7, 1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **159**

Major findings: Of operations _____

Of autopsy **None**

Duration _____
 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 **Tom W. Hart** (M. D. or other) **MD**
 Address **Med. Dir. Gen'l Hosp.** Date signed **6-7-46**

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. [Signature]

Licensed Embalmer No.....

3089

P. O. Address.....

1107 [Signature]

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.