

S. No. 2
M-5-43
y. 5-17-39
P I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23542**
3079
Registrar's No.

FILED JUL 31 1946
Registration District No. 149

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:
St. Vincents Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours 24 mins.
In this community 2 hrs 24 min. (Specify whether years, months or days)

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. 4530 Elmwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME INFANT COE
3. (b) If veteran No name war. 3. (c) Social Security No. none
4. Sex Female 5. Color or race White
6. (a) Single (Single, widowed, married, divorced) BABY
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 13th, 1946
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 13 year 1946 hour 5:17 minute 05 am M.
21. I hereby certify that I attended the deceased from July 12 1946 to July 13 1946
that I last saw h. alive on July 13 1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
0 0 0 2 hr 24 min.

Immediate cause of death Cardiovascular Premature separation of placenta
Due to _____
Duration _____

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

Other conditions (Include pregnancy within 3 months of death) 160c
Due to _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Baby
11. Industry or business _____
12. Name Robert Milton COE
13. Birthplace Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Wheeler
15. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Robert M. Coe, Father
(b) Address 4530 Elmwood, Kansas City, Mo.

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? _____

17. (a) Burial (b) Date thereof 7/15/46
(Burial, cremation, or ~~anyway~~) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cem. K.C. Kans.

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director Melody-McGilley-Eylar
(b) Address 1800 Linwood, Kansas City Mo.
19. (a) 7/15/46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature E. E. ... (M. D. or other) _____
Address 3850 Brown Date signed 7-13

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.....

[Handwritten Signature]
.....
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.