

S. No. 2
M-5-43
v. 5-17-39
I X36871

FILED AUG 95 1946

Registration District No. _____ Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
28
3
8
2552

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 **Trinity Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 hrs. 50 min.**
(Specify whether _____)
In this community **2 hrs. 50 min.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **Missouri** **67**
(c) City or town **BERTRAND**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **(Unnamed) McA Doo**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**
4. Sex **male** 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 **July 21, 1946**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **21**
year **1946** hour **12** minute **33 P.M.**
21. I hereby certify that I attended the deceased from **July 21**
1946 to **July 21**, 19 **46**
that I last saw him alive on **July 21 3:25 pm**, 19 **46**
and that death occurred on the day and hour stated above.
Immediate cause of death **subdural hemorrhage**
Duration _____

8. AGE: Years Months Days If less than one day
male **2 hr. 50 min.**
9. Birthplace **KANSAS CITY, MISSOURI**
(City, town, or county) (State or foreign country)
10. Usual occupation **new born premature**

Due to **laceration of Tentorium cerebelli**
Birth injury
massive hydroperi cardium
with atresia of pulmonary artery
Other conditions _____
(Include pregnancy within 3 months of death)
prematurity

MOTHER FATHER
12. Name **Dwight Winslow McA Doo**
13. Birthplace **Bertrand Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Ruth Isabelle Ball**
15. Birthplace **Covelo CALIFORNIA**
(City, town, or county) (State or foreign country)
16. (a) Informant **Dwight W. McA Doo**
(b) Address **Bertrand Missouri**
17. (a) **cremation** (b) Date thereof **July 22, 1946**
(Burial, cremation, or removal of body) (Month) (Day) (Year)
(c) Place of burial or cremation **Trinity Lutheran Hosp.**
18. (a) Signature of funeral director **Trinity Lutheran Hospital**
(b) Address **Kansas City Mo.**
19. (a) **7-26-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Underline the cause to which death should be charged statistically.
Major findings of operations **100C**
Of autopsy **above**
J. Williams Trinity Lutheran Hosp.
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? _____
23. Signature **W. B. Casbelle M.D.**
Address **1000 Ballou Ave** Date signed **7/24/46**

K E M O

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.