

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40452**

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **5536**

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. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 DAY** (Specify whether)

In this community **1 DAY**
years, months or days

3. (a) PRINT FULL NAME **INFANT BASTON**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **MALE** 2

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 **DECEMBER 27, 1946**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace **KANSAS CITY, MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business

MOTHER FATHER

12. Name **CLAUDE BASTON**

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

14. Maiden name **ANNA MAE MOORE**

15. Birthplace **ARKANSAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **ANNA MAE MOORE (MOTHER)**

(b) Address **1309 OLIVE**

17. (a) **Burial** (b) Date thereof **1-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lick St**

18. (a) Signature of funeral director **Wm A. Johnson**

(b) Address **city mortician**

19. (a) **12-31-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON** **48**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")

(d) Street No. **1309 OLIVE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **28,**
year **1946** hour **2:** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **DECEMBER 27,** 19 **46** to **DECEMBER 28,** 19 **46**
that I last saw h **IM** alive on **DECEMBER 28,** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **RESPIRATORY COLLAPSE** Duration

Due to **PREMATURITY**

Due to

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

Major findings: **PHYSICIAN**
Of operations
Of autopsy

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)

(d) Means of injury

23. Signature **Wm A. Johnson** (M. D. or other) **M.D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **12/30/46**

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

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. Schuyler

Licensed Embalmer No. *3089*

P. O. Address *HC MD*

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.