

No. 2
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17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40472
5426
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 min
(Specify whether
In this community 15 min
years, months or days)

3. (a) PRINT FULL NAME Infant Boyd
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. (c) Age of husband or wife if alive — years
7. Birth date of deceased 12 11 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
hr. 15 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 Lambert J. Boyd Jr. K.C. Mo.
13. Birthplace Chattanooga Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Thelma Adena Pope
15. Birthplace Carthage Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L J Boyd Jr.
(b) Address 20 West 36th K.C. Mo.

17. (a) (b) Date thereof 12 12 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Lukes Hospital

18. (a) Signature of funeral director St. Lukes Hospital
(b) Address 44th & Mill Creek Pkwy
19. (a) 12-27-46 (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. 20 West 36th 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 12 day 11
year 1946 hour 8 minute 32 P.M.
21. I hereby certify that I attended the deceased from 12-11-46
8:17 P.M. to 8:32 P.M. 12-11, 1946
that I last saw him alive on 12-11 and that death occurred on the date and hour stated above.

Immediate cause of death
Prematurity
Due to (5 1/2 mo)

Due to 159

Other conditions (Include only within 3 months of death)
Major findings: Theodore H. Aschman M.D.
Of operations
Of autopsy Prematurity

Duration
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 0
23. Signature (M. D. or other) 0
Date signed

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.