

FILED DEC 31 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10766

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5322

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: Kansas City Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hrs. (Specify whether
In this community 4 hrs. years, months or days)

3. (a) PRINT FULL NAME Nesbit infant

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 Dec 2 - 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. _____ min.

9. Birthplace K.C. MO
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER { 12. Name X
13. Birthplace Esther Nesbit
14. Maiden name Esther Nesbit
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Esther Nesbit

(b) Address 2520 Hoast

17. (a) Burial (b) Date thereof 12-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Wm. G. Johnson

(b) Address City

19. (a) 12-19-46 (b) Maldine 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. 1329 East 1st 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 Dec. day 2nd
year 1946 hour 11 minute 59 P. M.

21. I hereby certify that I attended the deceased from 12-2-46, 19, to 12-2-46, 19, that I last saw him alive on 12-2-46, 19, 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

22. If death was due to external causes, fill in the following:

(c) 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 _____

33. Signature Wm. G. Johnson (M. D. or other) MD
Address Med. Dir. K.C. Gen. Hosp. Date signed 12-2-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. Johnson

Licensed Embalmer No. *3089*

P. O. Address. *K C Mo*

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.