

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1168**
476
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. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days** (Specify whether
In this community **Life-long** years, months or days)

3. (a) PRINT FULL NAME **Baby Linda Leigh Jurgeson**
3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

4. Sex **female** / 5. Color or race **white**
6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years
7. Birth date of deceased **October 5 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- 3 26 hr. min.

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

10. Usual occupation **infant**

11. Industry or business **X**

MOTHER FATHER
12. Name **Russell Jurgeson**
13. Birthplace **Kansas City, Missouri** (City, town, or county) (State or foreign country)
14. Maiden name **Norma Rogers**
15. Birthplace **Kansas City, Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Russell Jurgeson**

(b) Address **7401 Indiana, Kansas City, Mo.**

17. (a) **burial** (b) Date thereof **2-3-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, Kansas City, Mo.**

19. (a) **2-1-47** (b) **Sheraldine 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. **7401 Indiana**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **31**
year **1947** hour **4:50** minute **P.** M.

21. I hereby certify that I attended the deceased from **10/8**
19 **46** to **1/31** 19 **47**
that I last saw her alive on **9-31-47** and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Due to **Acute upper respiratory infection**
Duration **2 weeks**

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

Major findings:
Of operations
Of autopsy **Essentially negative**
PHYSICIAN
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
Signature **Edward J. Shaw** (M. D. or other) **MD**
Address **200 W. 47** Date signed **2/1-47**

Dr. Shoren

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..... *J. Blair Sheppard*

Licensed Embalmer No. *4117A*

P. O. Address *R. C. M.*

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.

149

1002

476

Registration District No.

Primary Registration District No.

Registrar's No.

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. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Linda Leigh JURGESON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

4. Sex _____ 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-1-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31
year 1947 (hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I autopsied _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

I believe the baby's name on the
Due to original record was spelled
Linda Leigh JURGEON instead
Due to _____
of Jurgeson

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings:
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?
_____ (Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-1168