

S. No. 2
OM-5-43
v. 5-17-39
I X36671

FILED JAN 23 1947
149

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Childrens Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 hrs. 15 min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Matias Compes Mc Connell

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Dec 1 1946
(Month) (Day) (Year)

8. AGE: Years Months Day 4 If less than one day hr. 0 min. 0

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

10. Usual occupation infant

11. Industry or business _____

12. Name Matias Compos

13. Birthplace El Paso, Texas (City, town, or county) (State or foreign country)

14. Maiden name Florine Mc Connell

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

16. (a) Informant Mother

(b) Address 4117 Virginia

17. (a) Removal (b) Date thereof 1-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt. Hope K.C.

18. (a) Signature of funeral director John Stuebgen (Specify type of place) Home
(b) Address 1-C. W. Kansas (c) Means of injury _____

19. (a) 1-6-47 (b) Stadline Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town K. R. Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 4117 Virginia
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5
year 1947 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from Pathologist, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration 1 day

Due to M. Drasmus 5 15 days

Due to _____

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

Major findings: 108

Of operations _____

Of autopsy Same

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) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address 58 Park Hosp Date signed 5/2/47

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.....
....., 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.