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

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **8906**  
 Registrar's No. **1029**

**FILED MAR 21 1947**

Registration District No. 149 Primary Registration District No. 1802

**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. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 16 hrs  
(Specify whether in this community years, months or days)

**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. 437 Spruce  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Sharon Ann Birch  
 3. (b) If veteran, name war no 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**  
 20. **DATE OF DEATH:** Month March day 6  
 year 1947 hour 5 minute 30 A.M.

4. Sex female 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: March 6 1947  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 6, 1947, to March 3-6, 1947.  
 that I last saw her alive on March 3-6, 1947 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
				<u>16</u> hr. _____ min.

Immediate cause of death Cerebral failure Duration 2 hours  
 Due to atelectasis of lungs 12 hours  
 Due to prematurity - 6 months

9. Birthplace Kansas City Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation infant

Other conditions 159  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name Edward Birch  
 13. Birthplace Slater Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Marjorie Page  
 15. Birthplace Sweet Springs Missouri  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Edward Birch  
 (b) Address 437 Spruce, K.C. Mo.  
 17. (a) burial (b) Date thereof 3-7-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Calvary  
 18. (a) Signature of funeral director Earp & Sons  
 (b) Address 4139 East 15th  
 19. (a) 3-7-47 (b) Geraldine Holman  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_ Means of injury 0  
 23. Signature John T. Skene (M. D. or other) MD  
 Address 1525 Grand Ave Date signed 3-7-47

*Handwritten initials: J. C. M.D.*

**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 *John B. Carr*  
Licensed Embalmer No. *2935*  
P. O. Address *19. C. 9mo*

**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.**