

S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
FILED APR 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13530
State File No. 1669
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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hosp. X-10
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 46 hrs. 45 min
(Specify whether in this community - 46 hrs. 45 min
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48.
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1201 E. 42nd St. 8
(If rural, give location)
(e) Citizen of foreign country? no. 10
(Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME Sheryl Ann Larson
3. (b) If veteran, name war - no
3. (c) Social Security No. none

4. Sex Female
5. Color or race w
6. (a) Single, widowed, married, divorced single
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased 3-30-47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 hr. 45 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 Charles Oscar Larson
13. Birthplace Kansas City Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Gerre Caudill
15. Birthplace Jackson Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C.O. Larson
(b) Address 1201 E. 42nd St.

17. (a) cremation (b) Date thereof 4-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Luke's Hospital

18. (a) Signature of funeral director St. Luke's Hospital

(b) Address 443 and Mill Creek Blvd.
19. (a) 4-12-47 (b) Sheldine Holmes
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 1st
year 1947 hour 6:30 pm minute M.
21. I hereby certify that I attended the deceased from 3-30-
1947 to 4-1- 1947
that I last saw her alive on 4-1- 1947
and that death occurred on the date and hour stated above

Immediate cause of death Premature Infant Duration
with atelectasis.

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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 MI
Signature Murray R. Thron (M. D. or other) MI, D.
Address 1107 Bryant Bldg Date signed 4-11-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.