

S. No. 2  
M-8-43  
5-17-39  
PI X37823

17529

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUN 9 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2376

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

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: FAIRMOUNT HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 12 DA.  
In this community 12 DA.  
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. 1414 E 27 8  
(If rural, give location)  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PAMELA MARTINEZ

3. (b) If veteran, name war X 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 X years

7. Birth date of deceased MAY 12 1947  
(Month) (Day) (Year)

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

9. Birthplace KANSAS CITY MO. G  
(City, town, or county) (State or foreign country)

10. Usual occupation X infant

11. Industry or business X  
MOTHER FATHER {  
12. Name ROBERT H. PFEIFFER 9  
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)  
14. Maiden name JESSIE MARTINEZ  
15. Birthplace PICKREL NEBR. (City, town, or county) (State or foreign country)

16. (a) Informant FAIRMOUNT HOSPITAL  
(b) Address 1414 E 27

17. (a) Burial (b) Date thereof June 22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doehner  
(b) Address 1415 East 15

19. (a) 5-30-47 (b) Geraldine Holmbeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 29  
year 1947 hour 10 minute 20 P. M.

21. I hereby certify that I attended the deceased from 5-17  
1947, to 5-29 1947;  
that I last saw her alive on May 28 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Gastro-enteritis, Acute  
Due to Malnutrition  
Due to \_\_\_\_\_

Duration  
2 da

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 1190  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address 315 Brookside Plaza Date signed 5-30-47

**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..... *not embalmed* .....

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.**