

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:  
**FAIRMOUNT HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **21 DAYS**  
(Specify whether years, months or days)  
In this community **21 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. **1414 E 27**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **CHARLOTTE CHENORE**

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 **S**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive **X** years  
7. Birth date of deceased **JUNE 5 1947**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<b>21</b>	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 **LARRY WENNINGS** **9**  
13. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country)  
14. Maiden name **Wanita Chenore**  
15. Birthplace **HAMMOND IND.** (City, town, or county) (State or foreign country)

16. (a) Informant **FAIRMOUNT HOSPITAL**

(b) Address **1414 E 27**

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

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **G. P. Doshier**

(b) Address **1415 E 15**

19. (a) **6-30-47** (Date received local registrar) (b) **Theraldine Holmes** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **26**  
year **1947** hour **1** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **June 5**, 19**47**, to **June 5**, 19**47**;  
that I last saw her alive on **JUNE 26**, 19**47**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Inanition** Duration **21 days**

Due to **Premature birth**

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **159**

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? **0**

While at work? (Specify type of place) (e) Means of injury.....

23. Signature **Suditzkyger** (M. D. or other) **MD**

Address **510 Phyllis Bldg** Date signed **6-28-47**

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**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.**