

FILED NOV 8 1947 49

Registration District No. 149

Primary Registration District No. 1000

Registrar's No. 4531

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 General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 days
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Hougham Infant A

3. (b) If veteran,

name war no

3. (c) Social Security No.

none

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 Sept. 21, 1947
 (Month) (Day) (Year)

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

9. Birthplace Kansas City, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business Not known

MOTHER FATHER

12. Name "
 13. Birthplace "
 (City, town, or county) (State or foreign country)

14. Maiden name Lois Hougham
 15. Birthplace So, Dakota
 (City, town, or county) (State or foreign country)

16. (a) Informant Nearby Clerk
 (b) Address 1500 Gen. Hosp.
 17. (a) Burial (b) Date thereof 10-29-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bed's A

18. (a) Signature of funeral director Wm. D. Holmes
 (b) Address City, Missouri

19. (a) 10-29-47 (b) Sheraldine Holmes
 (Date received local registrar) (Registrar's signature)

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. 3815 Paseo
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5
 year 1947 hour 9 minute 10 A. M.

21. I hereby certify that I attended the deceased from Sept. 21 19 47 to Oct. 5 19 47
 that I last saw her alive on Oct. 5 19 47
 and that death occurred on the date and hour stated above.

Immediate cause of death

Prematurity

Due to

Due to

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

Major findings: Of operations

Of autopsy None

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?

(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 Wm. D. Holmes (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 10-6-47

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.....

not Embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed..... *Wm A. Schuyler*

Licensed Embalmer No. *3089*

P. O. Address *ITC MD*

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.