

FILED DEC 4 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36667

Registration District No. 109

Primary Registration District No. 1002

Registrar's No. 4630

## 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:  
Conley Maternity Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 minutes  
 (Specify whether  
 In this community 15 min  
 years, months or days)

3. (a) PRINT  
FULL NAMEInfant Kindred3. (b) If veteran,  
name war. NO3. (c) Social Security  
No. NONE4. Sex Male  
5. Color or  
race white6. (a) Single, widowed, married,  
divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased Nov 1 1948  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
hr. 15 min.9. Birthplace Kansas City Mo. 0  
(City, town, or county) (State or foreign country)10. Usual occupation NONE

11. Industry or business

MOTHER FATHER  
 { 12. Name Bernard LeRoy Kindred  
 { 13. Birthplace Edwardsville Kansas 1  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Dorothy Deane Goodfellow  
 { 15. Birthplace Kansas City Kansas 1  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dorothy Kindred(b) Address 962 Osage Ave. K.C. Ks.17. (a) Retained (b) Date thereof 11-12-48  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation K.C. College Osteopathy & Surgery  
Dept. of Anatomy

18. (a) Signature of funeral director

(b) Address Kansas City, Missouri19. (a) 11-12-48 (b) Seraldine Holman  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 962 Osage Ave 2  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1  
year 1948 hour 9:58 minute A M.21. I hereby certify that I attended the deceased from  
11-1, 1948 to 11-1, 1948  
that I last saw him alive on 11-1, 1948  
and that death occurred on the date and hour stated above.Immediate cause of death Deformity  
Incompatible with life

Duration

Due to Hydrocephalus

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death) 157a

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?

Edna M. Bangs

While at work? \_\_\_\_\_

(Specify type of place)

(e) Means of injury gSignature Edna M. Bangs (M. D. or other) D.O.Address 3639th St K.C. Mo Date signed 11-2-48

100-100000

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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.**