

FILED JAN 15 1949

Registration District No. **49**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 hrs. 52 min.  
(Specify whether  
In this community 6 hrs. 52 min.  
years, months or days)

3. (a) PRINT FULL NAME HOPE  
Harmoned Mullikin II

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 12 24 48  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day 6 hr. 52 min.

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

10. Usual occupation Infant

11. Industry or business Infant

12. Name Kenneth Forrest Mullikin

13. Birthplace Warren Arkansas  
(City, town, or county) (State or foreign country)

14. Maiden name Marion Lane Vance

15. Birthplace Oklahoma City Oklahoma  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mullikin (mother)

(b) Address 44 29 Gladstone

17. (a) Burial (b) Date thereof 12-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C.H. Blackman

(b) Address Kansas City, Missouri

19. (a) 12-27-48 (b) Gerardine 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. 4429 Gladstone  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 24  
year 48 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 12/24 1948 to 12/24 1948  
that I last saw her alive on 12/24  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature 5 1/2 MONTH  
lived about 6 hours

Due to Cause Unknown

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 159

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? \_\_\_\_\_

J. J. Farnsworth (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury D.

23. Signature J. J. Farnsworth (M. D. or other) \_\_\_\_\_

Address 1107 Grand Date signed 12/26/48

MOTHER FATHER

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

KC MV

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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.....  
*No Embalming*....., 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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**