

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8302**

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1100			
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City					
d. FULL NAME OF HOSPITAL OR INSTITUTION Florence Home for Colored Girls				d. STREET ADDRESS (If rural, give location) -- 2228 Campbell					
3. NAME OF DECEASED (Type or Print) Infant		a. (First) Carroll		b. (Middle)		c. (Last)			
5. SEX female		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH Feb. 26, 1949			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME --		13b. MOTHER'S MAIDEN NAME Lena Carroll		14. NAME OF HUSBAND OR WIFE --					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME Lena Carroll					
				ADDRESS 2228 Campbell					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) premature birth ANTECEDENT CAUSES DUE TO (b) syphilis Congenital DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 0202				INTERVAL BETWEEN ONSET AND DEATH 6 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Feb. 26, 1949 , to March 4, 1949 , that I last saw the deceased alive on March 4, 1949 , and that death occurred at m. , from the causes and on the date stated above.									
23a. SIGNATURE Eugene P. Chatman M.D. (Degree or title)				23b. ADDRESS 2202 1/2 E. 18th. St.		23c. DATE SIGNED 3-4-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3-11-49		24c. NAME OF CEMETERY OR CREMATORY Leeds		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
DATE REC'D BY LOCAL REG. 3-10-49		REGISTRAR'S SIGNATURE Sheraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Lohmeyer City Mortician					

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

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.