

FILED OCT 15 1949

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30623**
4135

BIRTH NO. 73174-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4135

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) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (in this place) 3 days			
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 730 Campbell Street	

3. NAME OF DECEASED (Type or Print) INFANT	a. (First)	b. (Middle)	c. (Last) TRICE	4. DATE OF DEATH (Month) AUGUST (Day) 18 (Year) 1949
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH AUGUST 14, 1949	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 8 Days 3 IF UNDER 11 HRS. Hours 8 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	10b. KIND OF BUSINESS-OR-INDUSTRY	11. BIRTHPLACE (State or foreign country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME BETTY TRICE	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME BETTY TRICE ADDRESS 730 Campbell Street

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ICTERUS NEONATORUM		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/11/, 19 49 to 8/18/, 19 49, that I last saw the deceased alive on 8/18/, 19 49 and that death occurred at 7:00A m., from the causes and on the date stated above.

23a. SIGNATURE Frank Ellis (Degree or title) Dec. M.D.	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 9/19/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-18-49	24c. NAME OF CEMETERY OR CREMATORY Leeds	24d. LOCATION (City, town, or county) (State) Leeds Jackson MO
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DATE REC'D BY LOCAL REG. 9-16-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Am. A. Holmes ADDRESS City Mortician
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(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.....

Not Embalmed

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Wm. A. Schuyler

Licensed Embalmer No. *3089*

P. O. Address *150 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.