

FILED OCT 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33765

State File No.

BIRTH NO. 50880-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4308

4838

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Polk</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Des-Moines</u>	
c. LENGTH OF STAY (in this place) <u>life</u>		d. STREET ADDRESS (If rural, give location) <u>316 & E. Palfrey Ave. Des Moines Iowa</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 16 1949</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Inf.</u> b. (Middle) c. (Last) <u>Bourdon A</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Inf.</u>	
8. DATE OF BIRTH <u>8-16-49</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days IF UNDER 11 HRS. Hours Min. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kansas city mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>--</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Grance Bourdon</u>	
14. NAME OF HUSBAND OR WIFE <u>--</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>	
16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lucy Grance Bourdon</u> ADDRESS <u>Des Moines</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Iowa	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
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 <u>7/10*</u>	
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) (Min.)		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 <u>Aug. 16, 19 49</u> , to <u>8-16</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Aug. 16</u> , 19 <u>49</u> , and that death occurred at <u>5:55P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title)		23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u>	
23c. DATE SIGNED <u>8-17-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-6-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Ledge Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Des Moines MO</u>	
DATE REC'D BY LOCAL REG. <u>10-10-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Will Johnson</u>		ADDRESS <u>1100 MO</u>	

Dr. Quinn

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 *110 7th*

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.