

REC'D FEB 20 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1171  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kan Primary Registration District No. 100  
 (c) City Kansas City (d) Street No. 72 Cogen Hosp St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Crisis Infant  
 (a) Residence, No. 520 W. 15th St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-14-39  
 7. AGE YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, 8 1/2 hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

FATHER 13. NAME Crisis Infant

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

MOTHER 15. MAIDEN NAME Frances M. Clarke

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

17. INFORMANT (ADDRESS) Record Clerk A. E. ...

18. BURIAL, CREMATION OR REMOVAL Field Ent DATE 1-17-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter G. ... 236 Campbell St

20. FILED Jan 16 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-14-39  
 22. I HEREBY CERTIFY, That I attended deceased from 1-14-39 to 1-14-39  
 I last saw him alive on 1-14-39. Death is said to have occurred on the date stated above, at 11:40 AM  
 The principal cause of death and related causes of importance were as follows:

Prematurity  
 159  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) P. H. De Maria, M. D.  
 (Address) 72 Cogen Hospital

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**