

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **Infant Selis 420**

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex **Male** 5. Color or race **wh** 6. (a) Single, widowed, married, divorced **Infant**

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **Sept 19th 1939**
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business **0**

MOTHER FATHER
12. Name **Frank Selis**
13. Birthplace **Kansas City Kas**
(City, town, or county) (State or foreign country)
14. Maiden name **Patricia Selis**
15. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Frank Selis**
(b) Address **2007 E. 34th St**

17. (a) **Burial** (b) Date thereof **9/20/39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **H. J. Mayberry**
(b) Address **2315 Linwood Blvd**

19. (a) **9/20/39** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Mary's Hosp**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19th**
year **1939** hour minute M.

21. I hereby certify that I attended the deceased from **9-20**, 19**39**, to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Spontaneous abortion due to prolapse of cord**
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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?

(Specify type of place) (e) Means of injury _____
While at work? _____

23. Signature **Dr. Hogan** (M. D. or other)
Address **415 Argyle Bldg** Date signed **9-20-39**

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

FORM 3-17-39 I X19511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. S. W. Rogers
W. Rogers
C. Rogers
Via 3845
1st to 4th

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 comply with the above constitutes grounds for revocation of license.)

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