

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(d) Length of stay: In hospital or institution ---
In this community --- years, months or days

3. (a) PRINT FULL NAME Carter infant
8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex F. 5. Color of race W. 6. (a) Single, widowed, married, divorced S.
6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased Nov. 26th 1939

8. AGE: Years Months Days If less than one day
br. 1 1/2 min.

9. Birthplace K.C., Mo.

10. Usual occupation None

11. Industry or business ---

MOTHER FATHER
12. Name John Carter
13. Birthplace Indiana
14. Maiden name Lydia Johnson
15. Birthplace Marquette Kansas

16. (a) Informant's own signature Record Clerk
(b) Address K.C. Gen. Hosp.

17. (a) Burial (b) Date thereof 12-4-39
(c) Place: burial or cremation Municipal Cem., Leeds, Mo.

18. (a) Signature of funeral director Wm. A. Johnson
(b) Address K.C. General Hospital, K.C. Mo.

19. (a) Dec. 1, 1939 (b) 211
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City, Mo.
(d) Street No. 2813 Holmes
(e) If foreign born, how long in U. S. A. --- years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November, 28th
year 1939 hour 4 minute 55 A.M. M.
21. I hereby certify that I attended the deceased from 11-26-39 to 11-26-39

that I last saw h. er alive on 11-26-39 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
Duration 159

Due to ---
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy See above
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? ---
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ---

While at work? --- (Specify type of place) (e) Means of injury ---
23. Signature P. F. De Maria MD (M. D. or other)
Address Supt. K.C. Gen. Hospital 12-1-39

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.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42168
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township J.C.
(c) City J.C.

Registration District No. 399
Primary Registration District No. 1002

Registered No. 4577

(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

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 8 (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 26, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from 19... to ... 19... I last saw him alive on ... 19... Death is said to have occurred on the date stated above, at ... m. The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

Other contributory causes of importance:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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

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

FATHER 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec 1, 1939 Dr. J. M. Brown Local Registrar

Name of operation Date of What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 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. J. De Marco M. D. (Address) Hospital Hill, J.C. Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms.

