

AUG 14 1940

STANDARD CERTIFICATE OF DEATH

24171

2781

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: K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Hrs.
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME SCHOLER INFANT (2) 460

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

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

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

7. Birth date of deceased June 22 1940
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
 hr. 5 Hrs. min. 0

9. Birthplace K.C. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

12. Name Donald Scholer

13. Birthplace Kansas
 (City, town, or county) (State or foreign country)

14. Maiden name Elsie Moore

15. Birthplace Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C. General Hospital, K.C. Mo.

17. (a) Burial (b) Date thereof 7-11-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried

18. (a) Signature of funeral director Wm. A. Johnson

(b) Address K.C. Gen. Hospital

19. (a) July 10, 1940 (b) M. M. Osborne
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2419 Charlotte
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd
 year 1940 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from
June 22nd 1940 to June 22nd 1940

that I last saw him alive on June 22nd, 1940, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) _____
 While at work? _____ (e) Means of injury _____

23. Signature R. F. De Maria M.D. (M. D. or other) _____
 Address Supt. Gen. Hospital, K.C. Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.