

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 8 1941 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41650
1002
Registrar's No. 5043

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Gen. Hosp. #3
(d) Length of stay: In hospital or institution 12-7-40-12-9-40
In this community 2 day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2121 Prospect
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Infant Boyd
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race Negro
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: 12 (Month) 7 (Day) 40 (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day hr. _____ min. _____

9. Birthplace: Kansas (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business 9
12. Name Unknown
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Johanna Mae Boyd
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hosp. #3

17. (a) burial (b) Date thereof 1-7-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Gen. Hosp. #3

18. (a) Signature of funeral director W. E. Sawyer
(b) Address R. E. Sawyer

19. (a) Dec. 31, 1940 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9
year 1940 hour 8 minute 50 P.M.
21. I hereby certify that I attended the deceased from 12-7-
1940 to 12-9 1940;
that I last saw him alive on 12-9 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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?
201 While at work? _____ (Specify type of place) _____ Means of injury _____
23. Signature W. E. Sawyer (M. D. or other) _____
Address _____ Date signed _____

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.