

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

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.

Rev. 5-17-39 I 43551

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1941
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13531

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 1512

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:
General Hospital #2 (1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-13-41-4-14-41
(Specify whether years, months or days) 4 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL.")
(d) Street No. 1421 Forest Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? 0 years.

3. (a) PRINT FULL NAME Infant Ferguson

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

4. Sex Male 2 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 4 13 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 4 hr. 0 min.

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

10. Usual occupation None

11. Industry or business _____

12. Name William Ferguson

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

14. Maiden name Helen Bailey
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 4-17-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

(b) Address 17 E. Gen. Hosp.

19. (a) Apr 16 1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14
year 41 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from 4-13- 1941 to 4-14- 1941
that I last saw him alive on 4-14- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature R. P. Johnson M.D. or other _____

Address Gen. Hosp. #2 Date signed 4-15-41

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.