

FILED SEP 3 1942
Registration District No. **749**

Primary Registration District No. **1002**

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

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: **Lakeside Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days**
(Specify whether years, months or days)

In this community **4 days**

3. (a) PRINT FULL NAME **Infant Wimsatt**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **same**

4. Sex **Male** 5. Color or race **wh.**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **no**

6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **aug-23-42**
(Month) (Day) (Year)

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

1 hr. **15** min.

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

10. Usual occupation **inf.**

11. Industry or business **no**

12. Name **Kenneth Wimsatt**

13. Birthplace **arche, mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Belle Wimsatt**

15. Birthplace **Parsons, mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kenneth Wimsatt**

(b) Address **Garden City, mo**

17. (a) **removal** (b) Date thereof **aug-23-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **aduan, mo**

18. (a) Signature of funeral director **F. I. Walton**

(b) Address **mo**

19. (a) **8-23-42** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **east**

(c) City or town **Garden City**
(If outside city or town limits, write "RURAL")

(d) Street No. **R.R. #9**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **aug** day **23rd**
year **1942** hour **12:00 P.M.** minute **0** M.

21. I hereby certify that I attended the deceased from **aug 19**
1942 to **aug 23** 19**42**

that I last saw him alive on **aug 23** 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Periparturient Paralysis due to Prematurity - Emergency a/cts appended of mother**

Due to **159**

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?

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

23. Signature **G. S. Hill** (M. D. or other)

Address **303 Harmon** Date signed **8-23-42**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, fact should be so stated above.