

S. No. 2  
M-5-1  
PI X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13087

FILED MAY 5 1943

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1784

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: Children's Mercy Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 minutes  
(Specify whether  
In this community 5 1/2 hours  
years, months or days)

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. 4409 St. John  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Chambers, Baby Boy

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced infant

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

7. Birth date of deceased 4 14 1943  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 1/2 hr. min.

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

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Earl Chambers

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

14. Maiden name Helen O. Edwards

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

16. (a) Informant Earl Chambers

(b) Address 4409 St. John

17. (a) Burial (b) Date thereof 4-16-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leval Hills

18. (a) Signature of funeral director John P. Skel  
(b) Address 6606 Independence Ave

19. (a) 4-15-43 (b) Dr. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1943 hour 11:40 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from April 14 11:25 AM, 1943 to April 14 11:40 AM, 1943  
that I last saw h. l. m. alive on April 14 - 11:40 AM, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration 6 hrs

Due to \_\_\_\_\_ 159

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

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_

23. Signature Charles Eldridge (M. D. \_\_\_\_\_)  
Address 6247 Brookside Blvd Date signed 4/15/43

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

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**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.**