

FILED JAN 17 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 69

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: St. Luke's
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 hr.
(Specify whether years, months or days)
 In this community 14 hr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 137 Cypress
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Pamela R. Stanley

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

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

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

7. Birth date of deceased Pamela Jan. 3, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 14 hr. min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name James Stanley

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

14. Maiden name Mary Madden

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

16. (a) Informant Mrs. Opal Stanley

(b) Address 137 Cypress

17. (a) Burial (b) Date thereof 1/1/55
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director C. H. Blackman & Son,
Kansas City, Mo.

(b) Address _____

19. (a) 1-6-45 (b) T. E. Brown (1/3)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
 year 1945 hour _____ minute _____ P; M.

21. I hereby certify that I attended the deceased from Jan 3 1945 to Jan 3 1945; that I last saw her alive on Jan 3 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Atelectasis

Due to Prematurity - wt. 3 lb 12 g

Due to _____

Other conditions 159
(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? _____

Inc. While at work _____ (Specify type of force) _____
(or) Means of injury

23. Signature Phil H. ... (M. D. or other) C.M.D.

Address 315 Alameda Rd Date signed 1-4-45

Duration

Birth

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *J. H. Blackman*

Licensed Embalmer No. *3639*

P. O. Address. *K. C. Mo*

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.