

FILED MAR 3, 1945

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 706

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
In this community 7 days
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. 902 E. 13 St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Inf Baughman

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

4. Sex Female
5. Color or race White
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 January 17 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 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 Richard Baughman
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K. C. General Hospital No. 1

17. (a) Burial (b) Date thereof 2-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address City

19. (a) 2-13-45 (b) T. E. Brown (1/3)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 24
year 1945 hour 4 minute 58 P. M.

21. I hereby certify that I attended the deceased from January 17 1945 to January 24 1945
that I last saw her alive on January 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Premature

Due to

Due to

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

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 A. E. Usher (M. D. or other)
Address Med. Dir. Gen'l Hosp

Date signed 1-25-45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Wm A. Schuyler

Licensed Embalmer No..... *3089*

P. O. Address..... *150 MP*

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.