

**FILED** SEP 20 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2736

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 Trinity Lutheran Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 min.  
 (Specify whether  
 In this community 10 min.  
 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. 1536 Lister  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME (UNNAMED) REED  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

4. Sex Female  
 5. Color or race w  
 6. (a)  Single,  widowed,  married,  divorced 0  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 2, 1945  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. 10 min.

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

10. Usual occupation new born

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

12. Name James H. Reed  
 13. Birthplace Kansas City, Kansas  
 (City, town, or county) (State or foreign country)

14. Maiden name Margaret E. Lester  
 15. Birthplace St. Joseph, Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant mother  
 (b) Address 1536 Lister, K.C. Mo.

17. (a)  Burial,  cremation, or removal  
 (b) Date thereof Sept. 3, 1945  
 (Month) (Day) (Year)

(c) Place: burial or cremation Interposition  
 18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) 9-8-45 (Date received local registrar)  
Trinity Lutheran Hospital (Name of institution)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month September day 2nd  
 year 1945 hour 11 minute 15 p. M.  
 21. I hereby certify that I attended the deceased from Sept. 2  
11:05 pm, 1945, to Sept 2 11:15 pm, 1945;  
 that I last saw her alive on Sept 2 11:00 pm, 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity  
Failure of respiration  
 Due to \_\_\_\_\_  
 Due to Prematurity

Other conditions (Include pregnancy within 3 months of death)  
 Major findings: 159  
 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)  
 Means of injury \_\_\_\_\_  
 Signature Wendell J. Anderson (M. D. or other)  
 Address 933 P. O. Bldg Date signed \_\_\_\_\_

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

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

8  
 3  
 8

**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.

*No undertaker  
Hospital made  
disposition of body*