

S. No. 2
 FORM-5-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **36092**

FILED DEC 6 1945
 Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4750**

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:
North East Hospital 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)
 In this community 7 Days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. 1221 Colorado **8**
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Donna Jean Brock
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 19th
 year 1945 hour 5 P.M. minute 30 M.

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 11 - 12 - 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 12 1945 to Nov 19 1945
 that I last saw her alive on Nov 19 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days 7 If less than one day hr. _____ min. _____

Immediate cause of death Prematurity
 Due to Deliver at approx 7 months
 Due to Uremia + Acute myocarditis of mother
 Other conditions None
(Include pregnancy within 3 months of death)

9. Birthplace Kansas City Missouri 0
(City, town, or county) (State or foreign country)

Major findings: None **159**
 Of operations _____
 Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation None

MOTHER FATHER
 11. Industry or business _____
 12. Name Clarence E. Brock
 13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)
 14. Maiden name Marie Closser
 15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mr. Clarence E. Brock
 (b) Address 1221 Colorado
 17. (a) Burial (b) Date thereof 11-20-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Memorial Park

While at work? _____
(Specify type of place)
 23. Signature Frank E. Day (M. D. or other) **100**
 Address 4314 E 9th, Keokuk Date signed _____
 No. 11-19-45

18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address Kansas City, Missouri
 19. (a) 11-20-45 (b) Meraldine Holmes
(Date received local registrar) (Registrar's signature)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by

....., Registered Apprentice No.

working under my personal supervision.

This baby was not embalmed

Signed

Theron A. Redman

Licensed Embalmer No. *2737*

P. O. Address

T.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.