

FILED JAN 21 1946

STANDARD CERTIFICATE OF DEATH

1335

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5510

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:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Alfred Jean Infants Dudley

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

4. Sex Female 5. Color or race Negro 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 December 15, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business None

12. Name John Dudley

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

14. Maiden name Alma Driffin

15. Birthplace Little Rock Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 1-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reed

18. (a) Signature of health director Wm A. Holman
(b) Address City of Springfield

19. (a) 12-31-45 (b) Shiraldine Holman
(Date received local registrar) (Registrar's signature)

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. 2300 Troost
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 24,
year 1945 hour 1:- minute 45 P.M.

21. I hereby certify that I attended the deceased from December 15, 1945 to December 24, 1945
that I last saw her alive on December 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Starvation

Due to Pyloric Stenosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1578

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? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address General Hospital #2 Date signed 12/26/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100267

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. [Signature]*

Licensed Embalmer No. *3089*

P. O. Address... *K C MD*

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.