

FILED APR 29 1946

Registration District No. 149

Primary Registration District No. 1002

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 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 da. 18 1/2 hrs.
(Specify whether
In this community 5 da. 18 1/2 hrs.
years, months or days)

3. (a) PRINT FULL NAME Baby girl Milligan
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. (c) Age of husband or wife if alive - years

7. Birth date of deceased 3 23 46
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 18 hr. 30 min.

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

10. Usual occupation infant

11. Industry or business

12. Name Wayne Eugene Milligan

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

14. Maiden name Leona Jean Packard

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

16. (a) Informant Mrs. W. E. Milligan
(b) Address 3701 1/2 Woodland

17. (a) (b) Date thereof 4-16-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Luke Hosp

18. (a) Signature of funeral director " " "
(b) Address " - c. mo.

19. (a) 4-16-46 (b) Sheraldine Holmes
(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. 3701 1/2 Woodland
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1946 hour 4:45 minute P. M.
21. I hereby certify that I attended the deceased from 3-23-46
....., 19....., to 3-29-46, 19.....
that I last saw her alive on 3-29-, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Anencephalic

Due to.....
Due to.....

Other conditions (Include pregnancy within 3 months of death) 157c

Major findings:
Of operations.....
Of autopsy Anencephalic

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 0
23. Signature Theodore H. Aschman (M. D. or other)
Address 1518 P. 2nd St. S. S. Mo. Date signed 4/13/46

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

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

12489

59
X36671

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.