S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 10 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20582

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2829

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: Menorah Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 hours 25 min. (Specify whether years, months or days)

In this community as above

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.: 1141 East 49th Street 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME: Infant WERKOWITCH

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: male 0

5. Color or race: white

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife: none

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: June (Month) 24 (Day) 1946 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day: 17 hr. 25 min.

9. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country) 1

10. Usual occupation: Infant

11. Industry or business:

MOTHER FATHER

12. Name: Wm. J. Werkowitch 0

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

MOTHER

14. Maiden name: Jean Frances Bynan

15. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country) 1

16. (a) Informant: Mr. Wm. Werkowitch

(b) Address: 1141 E. 49th., K.C., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-25-46 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery 1

18. (a) Signature of funeral director: Mellody-McGilley-Eylar

(b) Address: 1800 E. Linwood Blvd.

19. (a) 6-25-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24 year 1946 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from June 24, 1946 to June 24, 1946 that I last saw him alive on June 24, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Atelectasis

Due to: Prematurity

Due to:

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

Major findings:
Of operations:

Of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (c) Means of injury: 0

23. Signature: [illegible] (M. D. or other)

Address: 103 [illegible] Date signed: 6-26-46

(Licensed Embalmer's Statement on Reverse Side)

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 Russell N. France

Licensed Embalmer No. 4255

P. O. Address K. 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.