

**FILED NOV 5 1946**

Registration District No. 149

Primary Registration District No. 1002

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: Research Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 45 min.  
 In this community 45 min.  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3920 Olive  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

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

4. Sex Male 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 Oct 13 1946  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. <u>45 min.</u>

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

10. Usual occupation infant

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
 12. Name Winifred Merrill Wood  
 13. Birthplace Fort Scott Kans.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Virginia Lee Sarabee  
 15. Birthplace Haddon Kans.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. W. Wood  
 (b) Address Kansas City Mo.

17. (a) Cremation (b) Date thereof 10-10-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hosp  
 18. (a) Signature of funeral director H. C. ...

(b) Address 10-22-46 (c) St. ...  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 13  
 year 1946 hour 1 minute 55 PM.  
 21. I hereby certify that I attended the deceased from 10-13 1946 to 10-13 1946  
 that I last saw him alive on 10-13 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death anoxia  
 Due to placenta praevia

Other conditions 76°C  
 (Include pregnancy within 3 months of death)

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)  
 Means of injury ...  
 Signature ... (M. D. or other)  
 Address 1420 ... Date signed 10/24/46

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

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**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.**