No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37984

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4588

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 Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hr (Specify whether years, months or days)
In this community 5 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: 999
(c) City or town: Emporia (If outside city or town limits, write "RURAL") 14
(d) Street No.: 0 (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: Baby Cuyers
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 (Month) 18 (Day) 1947 (Year)
8. AGE: Years | Months | Days | If less than one day 5 hr. min.
9. Birthplace: Kansas City (City, town, or county) MO (State or foreign country)
10. Usual occupation: infant
11. Industry or business:
MOTHER FATHER
12. Name: Unknown
13. Birthplace: (City, town, or county) (State or foreign country)
14. Maiden name: Sarah Ruth Cuyers
15. Birthplace: Burns (City, town, or county) Kans. (State or foreign country)
16. (a) Informant: Sarah Ruth Cuyers
(b) Address: Emporia Kans.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Oct 19 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Research Hosp
18. (a) Signature of funeral director: Research Hosp.
(b) Address: K-C. Mo
19. (a) 11-3-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 1947 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from Oct 18, 1947, to Oct 18, 1947, that I last saw him alive on Oct 18, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to: 8 month – Atelectasis
Enlarged thymus

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: L4
Of autopsy: Enlarged thymus

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? (e) Means of injury: 0

23. Signature: Don Carlos Guffey M.D. (M. D. or other) 12/24/47
Address: 717 Poy Bldg. Date signed

(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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.