

FILED OCT 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33769

State File No.

4310

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SALINE</u>					
b. CITY (If outside corporate limits, write RURAL, and give town) <u>KANSASCITY</u>		c. LENGTH OF STAY (In this place) <u>2 months, 1 week</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>MARSHALL</u>		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The CHILDREN'S MERCY Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Route 2</u>					
3. NAME OF DECEASED (Type or Print)		a. (First) <u>RONALD</u>		b. (Middle) <u>WAYNE</u>		c. (Last) <u>BRESHEARS</u>			
4. DATE OF DEATH		(Month) <u>October</u>		(Day) <u>10</u>		(Year) <u>1949</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>October 21 - 1946</u>			
9. AGE (In years last birthday) <u>2 years</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Marshall Mo.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Elmer Marvin Breshears</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Marie Moore</u>		14. NAME OF HUSBAND OR WIFE <u>EtM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ELMER BRESHEARS</u>		ADDRESS <u>Marshall, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Symptomatic of left thorax</u>				ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>left thorax</u>					
				DUE TO (c) --					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from August 3, 1949, to October 10, 1949, that I last saw the deceased alive on October 10, 1949, and that death occurred at 6:40 a. m., from the causes and on the date stated above.									
23a. SIGNATURE <u>E. C. H. Schmidt</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>St. Luke's Hospital</u>		23c. DATE SIGNED <u>10-10-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10/10/49</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Marshall Mo.</u>			
DATE REC'D BY LOCAL REG. <u>10-10-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Shail Funeral Home K.C. Mo.</u> ADDRESS _____					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.4848
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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

John P. Sheil

Licensed Embalmer No. *3625*

P. O. Address *K.C. Mo.*

Signed.....
Student Embalmer

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.