

FILED AUG 4 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24393**
Registrar's No. **3281**

BIRTH NO. **50482** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MISSOURI b. COUNTY BIAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY NORTH	
c. LENGTH OF STAY (in this place) 3 DAYS		d. STREET ADDRESS (If rural, give location) 4103 Vivion Rd. 94	
3. NAME OF DECEASED a. (First) JAMES b. (Middle) Joseph c. (Last) COONS			4. DATE OF DEATH (Month) (Day) (Year) JULY 19 1952
5. SEX 0 MALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JULY 16 1952
9. AGE (In years last birthday) 3		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) KANSAS CITY, MO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME HOMER D. COONS		13b. MOTHER'S MAIDEN NAME JO ANN BROWN	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME HOMER D. COONS ADDRESS 4103 Vivion Rd.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kernicterus		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hemolytic disease of the newborn from both	
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) (Minute)		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 7/16, 1952 to 7/19, 1952 that I last saw the deceased alive on 7/18, 1952 , and that death occurred at a. m. , from the causes and on the date stated above.			
23a. SIGNATURE R. D. Dwyer, M.D. (Degree or title)		23b. ADDRESS 1902 North Platte, Mo	
23c. DATE SIGNED 7/19/52			
24a. BURIAL CREMATION (Specify)		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY EAST SLOPE Cem		24d. LOCATION (City, town, or county) (State) PLATTE Co. MO.	
DATE REC'D BY LOCAL REG. 7-21-52		REGISTRAR'S SIGNATURE Geraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE D.W. NEWCOMER'S SON'S		ADDRESS NORTH KANSAS CITY	

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

Glenn H. Hill

Signed.....
Student Embalmer

Licensed Embalmer No. 4586

P. O. Address. Quincy, 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.