

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

No. 300
10-48

FILED FEB 7 1953

BIRTH NO. 96184 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5834

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>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>Lifetime</u>		d. STREET ADDRESS (If rural, give location) <u>2121 East 15th Street</u> <u>3258</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #2</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>(Infant)</u>		b. (Middle)		c. (Last) <u>Wrice</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>3</u> <u>52</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>12-3-52</u>	
9. AGE (in years last birthday)		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 24 HRS. Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>America</u>	

13a. FATHER'S NAME <u>Isaac Wrice</u>		13b. MOTHER'S MAIDEN NAME <u>Eddie Lewis</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Eddie Lewis Wrice, 2121 E. 15th St.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fetal Atelectasis</u> ANTECEDENT CAUSES DUE TO (b) <u>Prematurity</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs 5</u>	
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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 12-3-52, 19 , to 12-3-52, 19 , that I last saw the deceased alive on 12-3-52, 19 , and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>E. Frank Kilis</u>		(Degree or title) <u>MD</u>		23b. ADDRESS <u>600 East 22nd Street</u>		23c. DATE SIGNED <u>12-8-52</u>	
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24a. BURIAL CREMATION (REMOVAL) (Specify)		24b. DATE <u>1-28-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Linds</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City MO</u>	
DATE REC'D BY LOCAL REG. <u>12-31-52</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ann Lohmeyer K.C. MO</u>			

WRITE PLAINLY—USING UNFAADING 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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Wm A. Schuyler*

Licensed Embalmer No. *3089*

P. O. Address *IT @ MD*

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.