

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6198**
1073

FILED MAR 13 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1073

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township:) OR TOWN <u>KANSAS Kansas City</u>	
c. LENGTH OF STAY (If this place) <u>10 1/2 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>985 Hillcrest Drive</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Children's Mercy Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>CHRISTINE GAY PAULSEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2 20 53</u>		
a. (First)	b. (Middle)	c. (Last)			

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>child 0</u>	8. DATE OF BIRTH <u>7-1-52</u>	9. AGE (In years last birthday) <u>7</u>	IF UNDER 1 YEAR Months <u>19</u> Days <u>4</u>	IF UNDER 1 MRS. Hours <u></u> Mins. <u></u>
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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 (City and State or Foreign Country) <u>Leavenworth, KS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Carleton Paulsen</u>	13b. MOTHER'S MAIDEN NAME <u>Marilyn Norris</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE, OR NAME <u>Father - Mr. Carleton Paulsen</u>	ADDRESS <u>112</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>7531</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral atrophy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>anoxia at birth</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"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 2-19, 1953, to 2-20, 1953, that I last saw the deceased alive on 2-20, 1953, and that death occurred at 8:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. M. Gilkey</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>1624 Prof Bldg.</u>	23c. DATE SIGNED <u>2-20-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-21-53</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Minneapolis, Minnesota</u>
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DATE REC'D BY LOCAL REG. <u>2-20-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE-MCCLURE</u>	ADDRESS <u>KANSAS CITY, MO.</u>
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Eugene Kemmer*

Licensed Embalmer No. *4673*

P. O. Address *240 9th*

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.