

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **10133**
Registrar's No. **1363**RECORDED MAR 27 1954
BIRTH NO. **9234** 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 Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Shawnee	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If rural, give location) 6011 Stearns	
3. NAME OF DECEASED (Type or Print) a. (First) Baby Boy b. (Middle) Trabon c. (Last) Trabon		4. DATE OF DEATH (Month) (Day) (Year) 2-20-1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 2-20-1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Joseph Miles Trabon		13b. MOTHER'S MAIDEN NAME Donna Pearl Doble	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mr. J. M. Trabon ADDRESS 6914 Stearns, Kans.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Congenital Atelectasis at birth INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature birth DUE TO (c) Abruptio placentae	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7615	
19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) 0	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) (Min.)	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 2-20, 1953 , to 2-20, 1953 , that I last saw the deceased alive on 2-20, 1953 , and that death occurred at 12:40 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Harold K. Gainey (Degree or title) MD		23b. ADDRESS 4635 W. 24th St.	
23c. DATE SIGNED 2/20/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Crementation	24b. DATE 2-23-53	24c. NAME OF CEMETERY OR CREMATORY St. Luke's Hospital	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 3-6-53	REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE St. Luke's Hosp. - K.C. Mo. ADDRESS

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.