

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

18846

BIRTH NO. 6470 46067-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2754

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>Johnson</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>4 hrs 25m</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Prairie Village</u> <u>9150</u>		TOWN
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>H. Mary's Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>4310 W. 71st STREET</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>		b. (Middle) <u>Joseph</u>	c. (Last) <u>Claypool</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-19-54</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>6-18-1954</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>-</u>
IF UNDER 1 YEAR Days <u>-</u>	IF UNDER 14 HRS. Hours <u>4</u>	IF UNDER 14 HRS. Min. <u>25</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never born</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>William Rud Claypool</u>		13b. MOTHER'S MAIDEN NAME <u>Sylvia Marie Downing</u>		14. NAME OF HUSBAND OR WIFE <u>-</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>Mr. William Claypool 4310 W. 71st.</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, ashenia, etc. It means the disease, injury, or complication which caused death.					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renal failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				<u>25 min</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hyaline Membrane Disease</u>				<u>174X</u>	
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) (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 <u>6-18</u> , 19 <u>54</u> , to <u>6-19</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>54</u> , and that death occurred at <u>2:05 a.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE Robert C. Fairchild (Degree or title) <u>Robert C. Fairchild, MD</u>			23b. ADDRESS <u>5829 Woodson Rd.</u>		23c. DATE SIGNED <u>6-19-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>June 20, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawn Haven Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Worthington, Pennsylvania</u>		
DATE REC'D BY LOCAL REG. <u>6-19-54</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D.H. Newcomer, Inc.</u> 1331 Brush Creek Kansas City, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

Basil Honey

Licensed Embalmer No. 4724

P. O. Address. K.C., 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.