

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15636**
2002

FILED MAY 24 1955

BIRTH NO. **299PP-55** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar No. **2002**

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

1. PLACE OF DEATH a. COUNTY Jackson County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) Life		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital		51. STREET ADDRESS (If rural, give location) 3026 McHEE 398	
3. NAME OF DECEASED a. (First) Robert (Type or Print)		b. (Middle) Eugene Thompson II	
c. (Last) Thompson II		4. DATE OF DEATH (Month) (Day) (Year) May 16 55	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 5-4-65
9. AGE (In years last birthday) 9		IF UNDER 1 YEAR Months 1 Days 11 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo		12. Foreign WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Eugene Thompson		13b. MOTHER'S MAIDEN NAME Jean Helen Feldman	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT'S SIGNATURE OR NAME Robert Eugene Thompson		ADDRESS K.C., Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart Disease.		ANTECEDENT CAUSES		1	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (b)		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		7544	
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) Kansas City Jackson Mo	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Russell W. Kerr (Degree or title) Pathologist		23b. ADDRESS St. Josephs Hospital		23c. DATE SIGNED 7 May 55	
----------------------------------------------------------------------------	--	------------------------------------------	--	----------------------------------	--

24. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-7-55		24c. NAME OF CEMETERY OR CREMATORY St. Joseph, Mo.	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. 5-7-55		REGISTRAR'S SIGNATURE Merna Minshall		25. FUNERAL DIRECTOR'S SIGNATURE Sidenfader ADDRESS St. Joseph, Mo.	
----------------------------------------	--	---------------------------------------------	--	-----------------------------------------------------------------------------------	--

2395

H. O. Seidenfaden

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.....
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.