

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18506

State File No.

BIRTH NO. 86938-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2289

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (in this place) <u>Life - 2 days</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>THE Childrens Mercy Hosp.</u>				STREET ADDRESS (If rural, give location) <u>4225 Scarritt 30880</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Paul. ANTHONY</u> b. (Middle) <u>Au</u> c. (Last) <u>Buchon</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-26-55</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (Specify) <u>0</u>		8. DATE OF BIRTH <u>12-5-54</u>		
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u>		IF UNDER 12 HRS. Hours <u>0</u> Mins. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>✓</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert AuBuchon</u>			13b. MOTHER'S MAIDEN NAME <u>Clara Knoppe</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>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Robert AuBuchon</u> ADDRESS <u>4225 Scarritt.</u>			
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) <u>Bilateral Bronchopneumonia</u>		II. OTHER SIGNIFICANT CONDITIONS <u>Infantile Muscular Atrophy</u>					7562	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mucoviscidosis cystic fibrosis of pancreas (congenital)</u> DUE TO (c) <u>Infantile Muscular Atrophy</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>5-24, 1955</u> , to <u>5-26, 1955</u> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>5-26, 1955</u> , and that death occurred at <u>6:35 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Wayne Hart</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Mercy Hosp</u>		23c. DATE SIGNED <u>5/26/55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/28/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Church</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John V. S. Hill - R.C. Ind.</u> ADDRESS				

(Licensed Embalmer's Statement on Reverse Side)

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

14626.

DL 525-0
Miss
Johnson

Miss Johnson

Miss Johnson

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.....
Thomas A. Steel

Licensed Embalmer No. 483
P. O. Address K.C. 9

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.