

no. 300  
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FILED AUG 11 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22157**  
**3222**  
Registrar's No.

BIRTH NO. **44022-55** 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 **MISSOURI** b. COUNTY **JACKSON**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **KANSAS CITY MO.**

c. CITY OR TOWN **KANSAS CITY**

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **ST. LUKES HOSPITAL**

STREET ADDRESS (If rural, give location) **5506 COLLEGE AVENUE**

3. NAME OF DECEASED  
a. (First) **BARBARA** b. (Middle) **LOBBRAINE** c. (Last) **GUNDY**

4. DATE OF DEATH (Month) (Day) (Year) **JULY - 28 1955**

5. SEX **FEMALE**

6. COLOR OR RACE **CAUC.**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **never married**

8. DATE OF BIRTH **7-19-55**

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. **9**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **INFANT**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) **KANSAS CITY MO**

12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **WALTER GUNDY**

13b. MOTHER'S MAIDEN NAME **HELEN HARDEN**

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **none**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **WALTER GUNDY 5506 COLLEGE AVENUE KANSAS CITY MO**

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) **Acute Mediastinitis**  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) **p.p. break-down of tracheo-esophageal fistula.**  
DUE TO (c)  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
**5391**

19a. DATE OF OPERATION **7-21-55**

19b. MAJOR FINDINGS OF OPERATION **TRACHEO-ESOPHAGEAL FISTULA**

20. AUTOPSY? YES  NO

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) m.

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

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 **David M. Gibson** (Degree or title) **David M. Gibson MD (Pathologist)**

23b. ADDRESS **St. Lukes Hospital Kansas City**

23c. DATE SIGNED **7/28/55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL**

24b. DATE **JULY 29 1955**

24c. NAME OF CEMETERY OR CREMATORY **FOREST HILL CEMETERY**

24d. LOCATION (City, town, or county) (State) **KANSAS CITY MISSOURI**

DATE REC'D BY LOCAL REG. **7-29-55** REGISTRAR'S SIGNATURE **Neva Marshall**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Dr. Newcomer 1331 BAYSH CREEK KANSAS CITY, MO.**

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 emb

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Wrapped + Packed*  
*Rollie Kessel*

Licensed Embalmer No. *4690*

P. O. Address *K.C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.