

FILED JAN 11 1956
87050-55

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40432**
5550

BIRTH NO. 1514 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5550

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Columbia	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 Florence Crittenton Home		STREET ADDRESS (If rural, give location) X	

3. NAME OF DECEASED (Type or Print) a. (First) "A" b. (Middle) c. (Last) Breedlove	4. DATE OF DEATH (Month) (Day) (Year) November 19 1955
---	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED (Specify) NEVER MARRIED	8. DATE OF BIRTH November 19, 1955	9. AGE (In years last birthday) 1 Months 15 Days	IF UNDER 1 YEAR Months 1 Days 15	IF UNDER 14 HRS. Hours 1 Min. 15
--------------------	-------------------------------	--	---	---	---	---

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, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.
--	-----------------------------------	--	--

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME Sharon Luane Breedlove	14. NAME OF HUSBAND OR WIFE none
--------------------	--	--

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 Sharon Luane Breedlove	ADDRESS Columbia
---	--	--	----------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 15 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		716X
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute) L m.	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 2:15pm 11-19-55, to 3:30pm 11-19-55, that I last saw the deceased alive on 11-19, 19 55, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE D.M. Love	D. M. Love (Degree or title) D.P.	23b. ADDRESS Prof. Bldg. Kansas City, Mo.	23c. DATE SIGNED 11-19-55
------------------------------------	--	---	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-19-55	24c. NAME OF CEMETERY OR CREMATORY Hospital Disposal	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. 12-21-55	REGISTRAR'S SIGNATURE Fred Marshall	25. FUNERAL DIRECTOR'S SIGNATURE David M. Gibson	ADDRESS St. Luke's Hosp. K.C. 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 embalmed by me, or by Student Embalmer No.
working under my personal supervision.. *Hospital Disposal -*

Student.....
Signature of Student Embalmer

Signed..... *David M. Gibson MD*
St. Luke's Hospital
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.