

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26323

State File No. \_\_\_\_\_

FILED SEP 4 1956  
BIRTH NO. 57092-56 REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN <u>Excelsior Springs</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Excelsior Springs</u>	d. In 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 <u>Excelsior Springs Hospital</u>		STREET ADDRESS (If rural give location) <u>109 N. Marquette</u>	

3. NAME OF DECEASED (Type or Print) <u>"INFANT"</u>	a. (First)	b. (Middle)	c. (Last) <u>DART</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7-26-56</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-26-56</u>	9. AGE (In years last birthday) <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>30</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Excelsior Springs, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Melvin Ray Dart</u>	13b. MOTHER'S MAIDEN NAME <u>Mary K. Darnsworth</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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 <u>Mary K. Dart</u>	ADDRESS <u>109 N. Marquette Excelsior Springs, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral anoxemia</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity</u>		
	DUE TO (c)		
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 <u>7625</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 26 July, 1956, to 26 July, 1956, that I last saw the deceased alive on 26 July, 1956, and that death occurred at 10:50 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George E. Anderson M.D.</u>	23b. ADDRESS <u>Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>7-29-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-28-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8/20/56</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Prichard Funeral Home, Inc.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

62-1



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed <sup>not</sup> by me, or by ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lindell Jarman*

Licensed Embalmer No. *4589*  
P. O. Address *Excelsior Springs,*

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.