Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30885
STATE FILE NUMBER

5739 3 8554-5 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3862

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 920 Forest — Length of stay in Institution: ~~4 Mo.~~ Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 920 Forest — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Deborah Middle: Jean Last: Newkirk

4. DATE OF DEATH: Month Sept. Day 2, Year 1956.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1956
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 3 Days 25 Hours Min. IF UNDER 24 HRS.

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 country): Kansas City Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert E. Newkirk
14. MOTHER'S MAIDEN NAME: Joan Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert E Newkirk 920 Forest Kansas City Mo. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 49 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Geo. C. Kealhofer (Degree or title) M.D.
22b. ADDRESS: 662 Rockhill Kansas City
22c. DATE SIGNED: 9-3-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 4, 1956.
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill
23d. LOCATION (City, town, or county) (State): Kansas City Mo.

24. FUNERAL DIRECTOR ADDRESS: Mrs. C. L. Forster Funeral Home Kansas City Mo.
25. DATE RECD. BY LOCAL REG.: 9-3-56
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J. Virgil Hennish

Licensed Embalmer No. 35 9

P. O. Address K C Ma

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.