

Health,
Welfare
Public
Service

300
1-56

Use only standard momentary ink for all symptoms to be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Gerald E. Hughes

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32262

STATE FILE NUMBER

3896

9449 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3896

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in ^{1b} 13 days	d. STREET ADDRESS (If outside, give location) 4508 Monroe Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) INFANT BRENDA KAY WILLARD First Middle Last			4. DATE OF DEATH August 18 1957 Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		100. KIND OF BUSINESS OR INDUSTRY Infant	9. AGE (In years last birthday) 13 IF UNDER 1 YEAR: Months 13 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. 0
11. BIRTHPLACE (City and State or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clyde T. Willard		14. MOTHER'S MAIDEN NAME Dixie Lou Swon	
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. No	17. INFORMANT Clyde T. Willard, 4508 Monroe. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PURULENT TRACHEO BRONCHITIS			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 8/15/57 to 8/18/57 and last saw her alive on 8/18/57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Gerald E. Hughes, M.D.		22b. ADDRESS 6509 Prospect, KC Mo	22c. DATE SIGNED 8/19/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-20-57	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home ADDRESS		25. DATE RECD. BY LOCAL REG. 8-19-57	26. REGISTRAR'S SIGNATURE Neve Minshall

6509
9889

19

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 *James W. Wair*

Licensed Embalmer No. *465*

P. O. Address *Kansas City*

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