

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will 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
Robert C. Jeffries

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35786

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4858

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City Mo</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Kansas City Mo</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Fairmount Hospital 24 hrs</i> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <i>4911 E 27th St</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Infant - Ellis</i> First Middle Last		4. DATE OF DEATH <i>10-17-1957</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-57</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>	9c. BIRTHPLACE (City and state or country) <i>Kansas City Mo</i>
10. FATHER'S NAME <i>unknown</i>		11. MOTHER'S MAIDEN NAME <i>Shirley Ellis</i>	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		13. SOCIAL SECURITY NO. <i>none</i>	
14. CAUSE OF DEATH [Enter only one cause of line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory failure.</i> <i>Premature (Twins).</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		15. INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		16. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17a. ACCIDENT <input type="checkbox"/>	17b. SUICIDE <input type="checkbox"/>	17c. HOMICIDE <input type="checkbox"/>	17d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
18. TIME OF INJURY Hour Month, Day, Year <i>a. m. p. m.</i>		19. CITY, TOWN, OR LOCATION COUNTY STATE	
20. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <i>10-16-57</i> to <i>10-17-57</i> and last saw him alive on <i>10-17-57</i> . Death occurred at <i>9:00</i> p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert C. Jeffries M.D.</i>		22b. ADDRESS <i>6344 Brookside Plaza</i>	
22c. DATE SIGNED <i>10-18-57</i>		23. NAME OF CEMETERY OR CREMATORY <i>Green Lawn Jackson Co Mo</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-22-57</i>	
24. FUNERAL DIRECTOR ADDRESS <i>France-Wornall Funeral Home</i>		25. DATE RECD. BY LOCAL REG. <i>10-21-57</i>	
26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>			

K/P
2

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 *Russell N. Frazer*

Licensed Embalmer No. *42*

P. O. Address *Kc m*

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.