

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH35824
STATE FILE NUMBER
4488

11645 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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, Mo.		c. CITY Kansas City OR TOWN 300 So	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in 1b Life	
3. NAME OF DECEASED (Type or print) Baby Boy Gluck		4. DATE OF DEATH Month 9 Day 21 Year 57	
5. SEX Male	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 9-21-57
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.
13a. FATHER'S NAME Robert Gluck		13b. MOTHER'S MAIDEN NAME Mary Ann Starr	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 Robert Gluck Address 1105 W. 85th Terr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) non viable premature			INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) precipitate labor			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) ruptured membranes			
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"/>			20b. 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 <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 9-21-57 , to 9-21-57 and last saw her alive on 9-21-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Bela K. Kent (Degree or title) Bela K. Kent M.D.		22b. ADDRESS 701 E 63rd Kansas City Mo	22c. DATE SIGNED 9-21-57
23a. BURIAL, CREMATION, REMOVAL (Specify) retained	23b. DATE 9-21-57	23c. NAME OF CEMETERY OR CREMATORY Menorah Medical Center	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Signed to Menorah Hospital		25. DATE RECD. BY LOCAL REG. 9-27-57	26. REGISTRAR'S SIGNATURE Neve Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

(Licensed Embalmer's Statement on Reverse Side)



1001

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

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.**