

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40271
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5197

S. 300
v. 1-57

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS (If outside, give location) 1328 Woodland	
3. NAME OF DECEASED (Type or print) Infant		4. DATE OF DEATH Sept. 26, 1957	
5. SEX 3 Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1957	
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, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Barbara Ann Robinson	
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 Barbara Ann Conn, mother		Address 1328 Woodland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis and prematurity.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			7625
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 9-26-57 to 9-26-57 and last saw her alive on 9-26-57 Death occurred at 5:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. R. Peterson MD		22b. ADDRESS 600 E. 22nd Street	
		22c. DATE SIGNED 10-31-57	
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE 11-7-57	
23c. NAME OF CEMETERY OR CREMATORY Linds		23d. LOCATION (City, town, or county) (State) Kansas City MO	
24. FUNERAL DIRECTOR W. R. Peterson		25. DATE RECD. BY LOCAL REG. 11-6-57	
ADDRESS K @ MO		26. REGISTRAR'S SIGNATURE Reva 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.

W. R. Peterson

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 Mat Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Am A Robinson

Licensed Embalmer No. 3089

P. O. Address K C MD

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.