

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH40272  
STATE FILE NUMBERRegistration District No. 149 Primary Registration District No. 1002 Registrar's No. 5196

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General #2</u>		Length of stay in lb <u>Life</u>		d. STREET ADDRESS <u>1328 Woodland</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle _____ Last <u>Conn</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1957</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>1</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>—</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Ann Robinson</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Barbara Ann Conn, mother 1328 Woodland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity.</u>						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) _____						7767	
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 type="checkbox"/> NO <input checked="" 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.) <u>—</u>				
20c. TIME OF INJURY . Hour _____ Month, Day, Year a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>9-26-57</u> to <u>9-27-57</u> and last saw her alive on <u>9-27-57</u> Death occurred at <u>9:25 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W. R. Peterson</u> (Type or print)				22b. ADDRESS <u>600 E. 22nd St.</u>			22c. DATE SIGNED <u>10-31-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>11-7-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leeds</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City MO</u>		
24. FUNERAL DIRECTOR <u>W. R. Peterson</u> ADDRESS <u>1100 N. C. MO</u>			25. DATE RECD. BY LOCAL REG. <u>11-6-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>		

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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.

Dept. Health,  
& Welfare  
S. Public  
Health ServiceS. 300  
ev. 1-57

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 Not Embalmed, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Anna Rohmeyer

Licensed Embalmer No. 3089  
P. O. Address KO 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.