. Health,
& Welfare
Public
h Service

S. 300
. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39094-58

58-029074
STATE FILE NUMBER 3719

AUG 20 1958

16950 Registration District No. 149 Primary Registration District No. 002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION The Childrens Mercy Hosp, Life — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri COUNTY Clay
c. CITY OR TOWN Kansas City, North 5004 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 4336 Colorado — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Karen Middle Lue. Last Eddings

4. DATE OF DEATH Month 8 Day 3 Year 1958

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June. 15, 1957

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months & Days 1-18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-

10b. KIND OF BUSINESS OR INDUSTRY INFANT

11. BIRTHPLACE (City and state or country) Kansas City Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Glen Eddings

13b. MOTHER'S MAIDEN NAME Lenora Reynolds

14. NAME OF HUSBAND OR WIFE None

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. None

17. INFORMANT Glen Eddings Address 4336 Colorado

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Organic Brain Damage — INTERVAL BETWEEN ONSET AND DEATH: 48 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) encephalopathy
DUE TO (c) neonatal anoxia — 7620
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 ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 7-9-58, to 8-3-58 and last saw her/him alive on 8-3-58
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wayne Hart (Degree or title) MD

22b. ADDRESS

22c. DATE SIGNED 8-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 8-3-58

23c. NAME OF CEMETERY OR CREMATORY Carver Cem.

23d. LOCATION (City, town, or county) (State) Hastings, Ark

24. FUNERAL DIRECTOR P. W. Newcomers, N.K.C.

ADDRESS

25. DATE RECD. BY LOCAL REG. 8-3-58

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Wayne Hart

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 John L Kalsbe

Licensed Embalmer No. 494

P. O. Address No. Kansas

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.