

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001280

STATE FILE NUMBER

400

FILED FEB 5 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 400

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Grandview, Mo.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>		Length of stay in lb <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>1301 Bennington</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl Enke</b>			4. DATE OF DEATH Month Day Year <b>1 7 1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 7, 1959</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
<b>1</b>		<b>7</b>	<b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>Charles Leroy Enke</b>	13b. MOTHER'S MAIDEN NAME <b>Doris Una Christenson</b>
14. NAME OF HUSBAND OR WIFE <b>none</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT <b>Doris Enke</b>		Address <b>1301 Bennington Grandview, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute peritonitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Life</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Volvulus + intussusception of small intestine</b>			<b>1 day</b>
DUE TO (c) <b>1561-</b>			
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK WHILE AT WORK <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 <b>1-7-59</b> to <b>1-7-59</b> and last saw her/him alive on <b>1-7-59</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Raymond J. Coffey MD</b>		22b. ADDRESS <b>Grandview, Mo.</b>	22c. DATE SIGNED <b>1-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Baby signed over to the department of Pathology - Menorah Medical Center for</b>			
24. FUNERAL DIRECTOR <b>scientific purposes Menorah Medical Center</b>		25. DATE RECD. BY LOCAL REG. <b>K.D. Mo. 1-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Irene Marshall</b>

MEDICAL CERTIFICATION  
Raymond J. Coffey MD ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
All diseases in Part I must be causally related.

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.