

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004635  
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 229

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>            |  | c. CITY OR TOWN <b>St. Joseph</b>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>410 S. 12th</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>410 S. 12th St.</b>   |  |
| Length of stay in lb<br><b>most of life</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>KENDRA</b> Middle <b>LEE</b> Last <b>TRAXSON</b> | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>28</b> Year <b>1959</b> |
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| 5. SEX <b>female</b> | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 7, 1958</b> | 9. AGE (In years last birthday)<br><b>5</b> Months <b>21</b> Days Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>infant</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
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| 13a. FATHER'S NAME<br><b>Gary Eugene Traxson</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Patricia McVey</b> | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> | 16. SOCIAL SECURITY NO.<br><b>none</b> | 17. INFORMANT<br><b>Gary E. Traxson, 410 S. 12th, St. Joseph, Mo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute poisoning</b>                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>accidental administration of cleaning fluid - 8:30</b><br>DUE TO (c) <b>14</b> |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Child Sycars of age administered</b>               |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 20a. ACCIDENT <input checked="" 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.)<br><b>cleaning fluid</b> |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. <b>2-28-59</b><br>p.m. | 20f. CITY, TOWN, OR LOCATION<br><b>1:31</b> |
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|   |  |   |                              |       |
|---|--|---|------------------------------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>at home</b> | 20f. CITY, TOWN, OR LOCATION<br><b>St. Joseph</b> | COUNTY<br><b>Buchanan Mo</b> | STATE |
|---|--|---|------------------------------|-------|

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| 21. I attended the deceased from <b>attended autopsy</b> and last saw her <b>2-28-59</b> on <b>2-28-59</b> Death occurred at <b>12:05 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE<br><b>St. Melaney M D</b> | 22b. ADDRESS<br><b>Ketchum Bldg. St. Joseph Mo</b> | 22c. DATE SIGNED<br><b>9-2-59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b> | 23b. DATE<br><b>3/2/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>Thorton-Bowman</b> | ADDRESS<br><b>St. Joseph, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>Mar. 2, 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Goodell</b> |
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All diseases in Part I must be causally related.  
Dr. S. E. Melaney

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Eugene Wood* .....

Licensed Embalmer No. *3804* .....

P. O. Address *319 Laith, St. J. Mo.* .....

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.