

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005825

STATE FILE NUMBER

463

FILED FEB 17 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300
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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hickman Mills, Mo. ⁷⁰⁰⁰		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.		Length of stay in lb <i>Life</i>	d. STREET ADDRESS 5601 E. 101st Terrace (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Infant Karen Lee Reed			4. DATE OF DEATH Month Day Year 1 - 23 - 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1959		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13a. FATHER'S NAME Ernest Ernest Reed		13b. MOTHER'S MAIDEN NAME Permelia Sturgel		14. NAME OF HUSBAND OR WIFE None	
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 Ernest Reed 5601 E. 101st. Terr. Hickma		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE - PIERRE - ROBIN SYNDROME</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>hypoplasia of mandible & cleft palate</i> DUE TO (c) <i>Prematurity - Broncho pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Prematurity - Broncho pneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH
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.) <i>7536</i>			
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 <i>1-22-59</i> to <i>1-23-59</i> and last saw ^{her} _{him} alive on <i>1-23-59</i> ✓ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert F. Lamar, M.D.</i> (Degree or title)			22b. ADDRESS <i>Professional Bldg</i>		22c. DATE SIGNED <i>1/23/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-24-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Missouri</i>	
24. FUNERAL DIRECTOR <i>Melody-McGilley-Eylar</i> ADDRESS <i>20 W. Linwood</i>		25. DATE RECD. BY LOCAL REG. <i>1-24-59</i>	26. REGISTRAR'S SIGNATURE <i>Nevar Minshall</i>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Robert F. Lamar

All diseases in Part I must be causally related.

201-835-1
201-2-4426

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.