

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017977

STATE FILE NUMBER

2291

FILED MAY 29 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-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) Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 3310 Denver Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pamela Middle Joy Last Tabron			4. DATE OF DEATH Month 5 Day 5 Year 59
5. SEX Female ³	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months 6 Days 6 Hours 6 Min.
11. BIRTHPLACE (City and state or country) Manassas city mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Joe Tabron		13b. MOTHER'S MAIDEN NAME Mildred Donahue	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 Joe Tabron Address 3310 Denver
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital blood dyscrasia			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) _____			
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 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.) 299X	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION Kansas City		20f. COUNTY MO STATE	
21. I attended the deceased from 5-3-59 to 5-5-59 and last saw her alive on 5-5-59 Death occurred at 9:20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Abraham Gelpert (Degree or title)		22b. ADDRESS General Hospital	22c. DATE SIGNED 5-7-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/7/59	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	23d. LOCATION (City, town, or county) (State) Kansas City MO
24. FUNERAL DIRECTOR Manlove Williams ADDRESS I729 Lydia		25. DATE RECD. BY LOCAL REG. 5-7-59	26. REGISTRAR'S SIGNATURE Neve Marshall

All diseases in Part I must be causally related.

Abraham Gelpert M.D. MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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. 4653

P. O. Address R. E. ...

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.