

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021736

STATE FILE NUMBER

FILED JUN 17 1959

16/86

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2721

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) OR TOWN Kansas City		c. CITY OR TOWN 138 Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		d. STREET ADDRESS (If outside, give location) 105 Ward PKWY.	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Trenton		4. DATE OF DEATH Month Day Year June 1 1959	
5. SEX Male	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 December 20, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		11. PLACE (City and county) Kansas City, Mo.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Clifford R. Trenton		13b. MOTHER'S MAIDEN NAME Carol Fels	
14. NAME OF HUSBAND OR WIFE Never Married		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 Address Clifford R. Trenton, Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchiolitis, complicated by DUE TO (b) Septicemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) F 491X			INTERVAL BETWEEN ONSET AND DEATH 48 Hours
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		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 Birth to June 1-59 and last saw ^{him} _{her} alive on June 1 1959 Death occurred at 5:00 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sidney F. Pakula M.D.		22b. ADDRESS 751 E. 63rd	
22c. DATE SIGNED June 2 59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 6-2-59		23c. NAME OF CEMETERY OR CREMATORY Rose Hill	
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.	
25. DATE RECD. BY LOCAL REG. 6-2-59		26. REGISTRAR'S SIGNATURE Neva Minshall	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Sidney F. Pakula

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 *Francis A. Walters*

Licensed Embalmer No. *2744*

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.