RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-025486
STATE FILE NUMBER

FILED VS JUL 27 1959

Registration District No. 19 Primary Registration District No. 1002 Registrar's No. 3356

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 1 day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St Joseph
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 918 Van Brunt
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Gayle Middle: Van Camp Last:
4. DATE OF DEATH: Month: July Day: 7 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: July 6, 1959
9. AGE (last birthday):
IF UNDER 1 YEAR: Months: Days: 1
IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Kansas City MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: Andy Van Camp
13b. MOTHER'S MAIDEN NAME: Nadine Zimmerling
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Andy Van Camp Address: 918 Van Brunt KC. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline Membrane — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Atelectasis — 8 hrs
DUE TO (c): Prematurity
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 time of birth to death and last saw her alive on 7-7-59
Death occurred at 12 30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF Leo M. Mullen

22a. SIGNATURE (Degree or title): Leo M. Mullen M.D.
22b. ADDRESS: 4443 Paseo Blvd
22c. DATE SIGNED: 7-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: July 10, 1959
23c. NAME OF CEMETERY OR CREMATORY: Green Lawn
23d. LOCATION (City, town, or county) (State): Kan City Mo.
24. FUNERAL DIRECTOR: Muehlebach ADDRESS: 6800 Troost K.C. Mo
25. DATE RECD. BY LOCAL REG.: 7-8-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed J. T. Crowell

Signature of Student Embalmer

Licensed Embalmer No. 4904

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.