URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 10 1959

59-036373
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5154

ENDED

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: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran
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) 4400 Jarboe
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First unnamed Middle girl Last Ritchey

4. DATE OF DEATH: Month 10 Day 8 Year 59

5. SEX: Female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10-6-59
9. AGE (last birthday)
IF UNDER 1 YEAR: Months Days 2
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
11. BIRTHPLACE (City and state or country): Kansas City-Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: —
13b. MOTHER'S MAIDEN NAME: Donna Patricia Ritchey
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: Donna Patricia Ritchey Address: 4400 Jarboe

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Agenesis of Abdominal Wall
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

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 10-6-59, to 10-8-59 and last saw her him alive on 10-8-59
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert F. Lamar (Degree or title) M.D.
22b. ADDRESS Prof. Bldg.
22c. DATE SIGNED 11 Oct 1959

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 15 Oct 59
23c. NAME OF CEMETERY OR CREMATORY Trinity Hospital
23d. LOCATION (City, town, or county) (State) KC Mo.

24. FUNERAL DIRECTOR Pathologist J. Jossill, MD. ADDRESS Trinity Hospital
25. DATE RECD. BY LOCAL REG. 10-26-59
26. REGISTRAR'S SIGNATURE Neva Minnehall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert F. Lamar

DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____ not embalmed _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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