

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006184

FILED VS MAR 7 1960 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1017

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in lb <u>10 days.</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Childrens Mercy Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JACKSON.</u> c. CITY OR TOWN <u>KANSAS CITY.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3320 Woodland Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Micah Howard Byrnes.</u>			4. DATE OF DEATH Month Day Year <u>2-19-60.</u>				
5. SEX <u>Male.</u>	6. COLOR OR RACE <u>White.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-59</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> IF UNDER 24 HR: Hours <u>4</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Sedalia, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>James Dean Byrnes.</u>		13b. MOTHER'S MAIDEN NAME <u>Marian Beechle Chapman.</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>KANSAS CITY</u> <u>James Dean Byrnes-3320 Woodland Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Overwhelming Staphylococcus Pneumonitis.</u> 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) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input 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.)				
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>2-9-60</u> <u>8:05</u> to <u>2-19-60</u> and last saw her/him alive on <u>2-19-60</u> Death occurred at <u>8:05</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>S. Renner M.D.</u>			22b. ADDRESS <u>Kansas City Mo.</u>		22c. DATE SIGNED <u>2.20.60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2.20.60</u>	23c. NAME OF CEMETERY OR CREMATORY _____		23d. LOCATION (City, town, or county) (State) <u>Sedalia Mo.</u>		
FUNERAL DIRECTOR <u>Quam Camp</u>		ADDRESS <u>SEDALIA, MO</u>		25. DATE RECD. BY LOCAL REG. <u>2.20-60</u>	26. REGISTRAR'S SIGNATURE <u>neva minchall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed Quene Enery

Licensed Embalmer No. 3847
P. O. Address Lodolia, MD

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