

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023423

FILED VS. JUL 5 1960

149

Primary Registration District No. 1002 Registrar's No.

3332

STATE FILE NUMBER

| | | | | | | | |
|--|---|---|---|--|---|--|--|
| 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 | | Length of stay in 1b Life | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Conley Maternity Hospital | | | | d. STREET ADDRESS (If outside, give location) 1018 Bellefontaine | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DEBRA Middle LYNNE Last STEWART | | | | 4. DATE OF DEATH Month June Day 10 Year 1960 | | | |
| 5. SEX Female | 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 6/9/60 | 9. AGE (last birthday) 1 | IF UNDER 1 YEAR Months 1 Days 1 | IF UNDER 24 HR Hours 1 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and state or country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Robert Wayne Stewart, Sr. | | | 13b. MOTHER'S MAIDEN NAME Lynetta Wilkins | | 14. NAME OF HUSBAND OR WIFE Lynetta Stewart | | |
| 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 Lynetta Stewart Address 1018 Bellefontaine | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Spinae Bifida Congenital DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 6/9/60 to 6/10/60 and last saw <u>her</u> him alive on 6/10/60 Death occurred at 12:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Myron D. Jones D.O. | | | | 22b. ADDRESS 926 E 11th St | | 22c. DATE SIGNED 6/22/60 | |
| 23a. BURIAL CREMATION, (Specify) Relaxed | 23b. DATE 6/10/60 | 23c. NAME OF CEMETERY OR CREMATORY K. C. College of Osteopathy & Surgery, K. C., Mo. | | 23d. LOCATION (City, town, or county) (State) | | | |
| 24. FUNERAL DIRECTOR K.C. College of Osteopathy, K.C. Mo. | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 6-23-60 | 26. REGISTRAR'S SIGNATURE Beva Marshall | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Myron D. Jones

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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