

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044634

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6636

AMENDED

FILED JAN 1 1962

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>                   |  | Length of stay in lb. OR TOWN <u>2 hours 33"</u>  | c. CITY OR TOWN <u>Pleasant Hill</u>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>400 Vermont</u> |

|   |                              |   |  |   |
|---|------------------------------|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Baby Boy Dinges</u>                                    |                              |   | 4. DATE OF DEATH<br>Month Day Year<br><u>12-3-61</u> |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>w</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12-3-61</u>                   | 9. AGE (last birthday)<br>IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.<br><u>2 23</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)<br><u>Kansas City Mo.</u>                              |
| 13a. FATHER'S NAME<br><u>Donald Floyd Dinges</u>  |                              | 13b. MOTHER'S MAIDEN NAME<br><u>Paula Nelle Brown</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Paula Nelle Brown 400 Vermont</u>                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> |                              | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  | 17. INFORMANT<br><u>Paula Nelle Brown 400 Vermont</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) Menenphalic - congenital

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) birth defect

DUE TO (c) \_\_\_\_\_

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 12-3-61 to 12-3-61 and last saw him alive on 12-3-61  
Death occurred at 11:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)  
W. Eklund MD.

22b. ADDRESS  
Pleasant Hill, Mo.

22c. DATE SIGNED  
12-27-61

23. BURIAL, CREMATION, REMOVAL, Spec. Hospital Disposal 23b. DATE 12-3-61 23c. NAME OF CEMETERY OR CREMATORY \_\_\_\_\_ 23d. LOCATION (City, town, or county) (State)  
Kansas City Mo.

24. FUNERAL DIRECTOR ADDRESS  
St. Lukes Hosp. K.C. Mo.

25. DATE RECD. BY LOCAL REG. 1-4-62

26. REGISTRAR'S SIGNATURE  
Ruth Long

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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.

*Hospital Despair*

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *David W. Nelson MD*

Licensed Embalmer No. \_\_\_\_\_

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.