S. No. 300
V. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8673

BIRTH NO. 49-015624 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 907

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City, Missouri
c. LENGTH OF STAY (in this place): 1:48 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Trinity Lutheran Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Jackson 46
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 3.
d. STREET ADDRESS (If rural, give location): 21-E-30th Street 3

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): Fenton
c. (Last): Waldrop JR

4. DATE OF DEATH (Month) (Day) (Year): 2-26-49

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: 2-26-49
9. AGE (In years last birthday): If under 1 year: Months / Days: Hours 1 / Min. 48

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KANSAS CITY Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Robert Fenton Waldrop
13b. MOTHER'S MAIDEN NAME: Dorothy Helen Camerer
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: Mrs Waldrop
ADDRESS: 21 East 30th Apt. 3B

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

7lb X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2-26, 1949, *to* 2-26, 1949, *that I last saw the deceased alive on* 2-26, 1949, *and that death occurred at* 6:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John M. Powers (Degree or title): D.M.D.
23b. ADDRESS: 3304 Linwood
23c. DATE SIGNED: 2/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: FEB 28 1949
24c. NAME OF CEMETERY OR CREMATORY: Local
24d. LOCATION (City, town, or county) (State): BUTLER Mo

DATE REC'D BY LOCAL REG.: 2-26-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Mrs C.L. Fowler
ADDRESS: Butler, Mo

(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 me, or by _____ Student Embalmer No. _____, working under my personal supervision.

Signed Lou Hark

Signed _____
Student Embalmer

Licensed Embalmer No. 4216

P. O. Address Kc. Mo

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 this body is not embalmed, fact should be so stated above.