

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 15889
2026BIRTH NO. 34389-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

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, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) OR TOWN 8 hours	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 4118 Bellefontaine	
3. NAME OF DECEASED (Type or Print) a. (First) Infant		b. (Middle) GRANSTEDT (A)	
c. (Last) GRANSTEDT (A)		4. DATE OF DEATH (Month) (Day) (Year) May 7, 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH May 7, 1949
9. AGE (In years last birthday) Months Days 8		10. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John Granstedt		13b. MOTHER'S MAIDEN NAME Mary Janice	
14. NAME OF HUSBAND OR WIFE John Granstedt		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. no		17. INFORMANT'S SIGNATURE OR NAME John Granstedt, 4118 Bellefontaine, KC, Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis ANTECEDENT CAUSES Prematurity 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. 7625	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 7, 1949 , to May 7, 1949 , that I last saw the deceased alive on May 7, 1949 and that death occurred at 9:40 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Robert C. Swisher, M.D.		23b. ADDRESS 15509 Brookside Blvd	
23c. DATE SIGNED May 9, 1949		23d. DATE	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-10-49	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
DATE RECD BY LOCAL REG. 5-9-49		REGISTRAR'S SIGNATURE Sheraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGillev-Eylar		ADDRESS Kansas City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Anzures
5509 Binkley

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.

Student
Student Embalmer

Signed Max St. Kirkendall

Licensed Embalmer No. 4632

P. O. Address K.C., 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.