

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15947
1929

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>North Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>2 Hr. 40"</u>		d. STREET ADDRESS (If rural, give location) <u>Rt 487</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Children's Mercy Hospital</u>			
3. NAME OF DECEASED a. (First) <u>Kenneth</u> b. (Middle) <u>Marvin</u> c. (Last) <u>Jacobson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 1 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>24 March 3, 1947</u>
9. AGE (In years last birthday) <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Austin, Minnesota</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>LESTER</u>		13b. MOTHER'S MAIDEN NAME <u>MARJORIE STEVENSON</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Father & mother</u> ADDRESS <u>RR 487 N. KC Mo</u>
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Laryngeal edema.</u> 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) <u>CAUSE undetermined.</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>517X</u>	
19a. DATE OF OPERATION <u>5/1/49</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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 <u>May 1, 1949</u> , to <u>May 1, 1949</u> , that I last saw the deceased alive on <u>May 1, 1949</u> , and that death occurred at <u>12:40</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E.C.H. Schmidt</u>		23b. ADDRESS <u>St. Lukes Hosp.</u>	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5-3-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Le Roy Minn</u>		24d. LOCATION (City, town, or county) (State) <u>Le Roy Minn</u>	
DATE REC'D BY LOCAL REG. <u>5-3-49</u>		REGISTRAR'S SIGNATURE <u>Steraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Morton-Smith's</u>		ADDRESS <u>North K.C. Mo.</u>	

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

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

Heron Smith

Licensed Embalmer No. *3928*

P. O. Address *North Kansas City*

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.