

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19656
2751

BIRTH NO. 35254-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Kansas City Mo</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Kansas City, Mo 563</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Trinity Lutheran Hosp</i>		d. STREET ADDRESS (If rural, give location) <i>3004 Linwood Blvd</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Carolyn</i> (Middle) <i>Louise</i> (Last) <i>Limbrook</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>June 23-1949</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>wh</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Infant</i>	8. DATE OF BIRTH <i>June 23-1949</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Missouri</i>
13a. FATHER'S NAME <i>Raymond Limbrook</i>		13b. MOTHER'S MAIDEN NAME <i>Mattie L. Limbrook</i>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Raymond Limbrook 196 Mo</i>

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) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Laceration of Tentorium</i>		
		DUE TO (c)		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Breech presentation</i>		
19a. DATE OF OPERATION	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) (Min.)	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 *Pathologist*, 19___, that I last saw the deceased alive on ___ 19___, and that death occurred at ___ from the causes and on the date stated above.

23a. SIGNATURE <i>Jack H. Hill</i> (Degree or Title) <i>D.M.D.</i>	23b. ADDRESS <i>Trinity Lutheran Hospital</i>	23c. DATE SIGNED <i>24 June 49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24b. DATE <i>June 24th</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Braymer</i>	24d. LOCATION (City, town, or county) (State) <i>Braymer Mo.</i>
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DATE REC'D BY LOCAL REG. <i>6-25-49</i>	REGISTRAR'S SIGNATURE <i>Sheldine Holmes</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Demandt Mead Braymer</i>
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(Licensed Embalmer's Statement on Reverse Side)

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 John W. Laybawme

Licensed Embalmer No. 1715

P. O. Address H. E. 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.