

THE DIVISION OF HEALTH OF MISSOURI

FILED AUG 6 1949

STANDARD CERTIFICATE OF DEATH

State File No. **23462**
3088

BIRTH NO. **28748-49** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **3088**

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 OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 19d. 14 1/2		d. STREET ADDRESS (If rural, give location) 129 E 31	
d. FULL NAME OF HOSPITAL OR INSTITUTION The Children's Mercy Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) STEVEN EARL b. (Middle) JAMES c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 7-15-49
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 25-1949	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Virgil Carl James	13b. MOTHER'S MAIDEN NAME Mariorie Sue Keel	14. NAME OF HUSBAND OR WIFE None
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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. Virgil Carl James ADDRESS 129 E 31st K.C., Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelaxia, left		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. of left hydrothorax		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 51	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **June 21, 1949**, to **July 15, 1949**, that I last saw the deceased alive on **July 15, 1949**, and that death occurred at **11:05 m.**, from the causes and on the date stated above.

23a. SIGNATURE (E. C. H. Schmidt M.D.) (Degree or title)	23b. ADDRESS	23c. DATE SIGNED July 15-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-16-1949	24c. NAME OF CEMETERY OR CREMATORY Mt Washington	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 7-16-49	REGISTRAR'S SIGNATURE Sheraline Holme	25. FUNERAL DIRECTOR'S SIGNATURE C. H. Blackman & Son, Inc ADDRESS Kansas City Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

No. 300
10.48

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.....

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