

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23538**
2966
Registrar's No.

BIRTH NO. **34842-49** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (In this place) 29hrs		d. STREET ADDRESS (If rural, give location) 2500 Highland Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2			

3. NAME OF DECEASED (Type or Print) a. (First) DONNA M	b. (Middle) MARIE	c. (Last) MOORE	4. DATE OF DEATH (Month) (Day) (Year) JUNE 5 1949
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JUNE 4 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) (last birthday) (If under 1 year: Months) (Days) (If under 12 hrs: Hours) (Mins) 29 21
11. BIRTHPLACE (State or foreign country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME LYLE ROBERTA THOMPSON	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME LYLE ROBERTA MOORE
		ADDRESS 2500 Highland

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CRANIOSCHISTIS		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. HEMICRANIA MENINGO ENCEPHALOCELE		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 751x	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) (m.)	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 **6/6/49**, 19 **49**, to **6/5/49**, 19 **49** that I last saw the deceased alive on **6/5/49**, 19 **49**, and that death occurred at **12:05P** m., from the causes and on the date stated above.

23a. SIGNATURE OF REGISTRAR Frank Ellis	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 6/29/49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-4-49	24c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery
24d. LOCATION (City, town, or county) (State) Sub Station Jackson MO		

DATE REC'D BY LOCAL REG. 7-8-49	REGISTRAR'S SIGNATURE Eraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Wm A. Johnson	ADDRESS 112 MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5-899

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 _____

Not embalmed

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed *Wm A. Robinson*

Licensed Embalmer No. *3089*

P. O. Address *N.C. MD*

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.