

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30454

State File No. _____

3754

BIRTH NO. 72737-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Eastside Hospital Jackson Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Chautauque</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas city mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedan</u>	
c. LENGTH OF STAY (In this place) <u>3 hrs.</u>		d. STREET ADDRESS (If rural, give location) <u>1700</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Eastside Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant</u> b. (Middle) <u>mills.</u> c. (Last) <u>mills.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 28, 1949</u>		
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5. SEX <u>M. W.</u>	6. COLOR OR RACE <u>Infant</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Aug 28 - 1949</u>	9. AGE (10 years last birthday) <u>3</u>	10. UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	11. UNDER 1 HR. Hours <u>3</u> Min. <u>3</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Kansas City Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Robert E. Nowell</u>	13b. MOTHER'S MAIDEN NAME <u>Phyllis M. Mills</u>	14. NAME OF HUSBAND OR WIFE <u>Phyllis M. Mills</u>
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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. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Phyllis M. Mills</u> ADDRESS <u>Sedan Kans</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intra Uterine Asphyxia</u> <u>Premature Rupture of Membranes</u> DUE TO (c) <u>Premature Placental Separation</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prematurity</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>7615</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>3:30 p.m.</u>	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 Aug 28, 1949, to Aug 28, 1949, that I last saw the deceased alive on Aug 28, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Maurice M. Geraghty, D. O.</u>	23b. ADDRESS <u>6055 Trimmer Rd. KCMO</u>	23c. DATE SIGNED <u>8/24/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>sep 3 - 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Columba</u>	24d. LOCATION (City, town, or county) (State) <u>K.C. Kas.</u>
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DATE REC'D BY LOCAL REG. <u>8-31-49</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	FUNERAL DIRECTOR'S SIGNATURE <u>P. A. Theissen</u>	ADDRESS <u>6900 Troost</u>
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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.

Signed.....

Ph. Thelen

Signed.....

Student Embalmer

Licensed Embalmer No. *2351*

P. O. Address *8900 Transit ave*

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.