

FILED FEB 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1257

State File No. 216

BIRTH NO. 8128-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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. LENGTH OF STAY (in this place) 44 3/4 days	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Children's Mercy Hospital		d. STREET ADDRESS (If rural, give location) Fairmount Maternity Hosp.	
3. NAME OF DECEASED a. (First) Lucien Londenbarger		4. DATE OF DEATH (Month) (Day) (Year) 1 13 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Jan-10-50
9. AGE (in years last birthday) 2 Days		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Fairmount Hospital, K.C. Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Cecile Londenbarger	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) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fairmount Hosp 1414 E 27

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* Intracranial Hemorrhage Cause and Jaundice  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 1-10, 1950, to 1-13, 1950, that I last saw the deceased alive on 1-10, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE R. A. McCarson (Degree or title) M.D. 23b. ADDRESS Bryant Bldg. 23c. DATE SIGNED Jan 13 1950

24a. BURIAL, CREMATION (REMOVAL) (Specify) Burial 24b. DATE Jan-17-50 24c. NAME OF CEMETERY OR CREMATORY Green Lawn 24d. LOCATION (City, town, or county) (State) Norman Mills Mo

DATE REC'D BY LOCAL REG. 1-16-50 REGISTRAR'S SIGNATURE Geraldine Holmes 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. P. Roehler 1415 E 15

(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 \_\_\_\_\_

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*T. P. Doehler*

Licensed Embalmer No. \_\_\_\_\_

*1166*

P. O. Address \_\_\_\_\_

*.1415 E 15*

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.