

FILED MAY 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16965
2076

BIRTH NO. 28423-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2076

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mission	
c. LENGTH OF STAY (In this place) 11 hrs.		d. STREET ADDRESS (If rural, give location) 5343 Briar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) Rae c. (Last) Stauffer		4. DATE OF DEATH (Month) (Day) (Year) 5 - 4 - 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH May 3, 1950
9. AGE (In years last birthday) 11		IF UNDER 1 YEAR Months 11 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Clifford J. Stauffer	
13b. MOTHER'S MAIDEN NAME Mary F. Garmon		14. NAME OF HUSBAND OR WIFE --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Clifford J. Stauffer, Mission, Kansas		ADDRESS	

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) Atelectasis, Congenital		ANTECEDENT CAUSES		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Toxemia of Pregnancy		
		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS		Delivered by Cesarean section		2 wks
Conditions contributing to the death but not related to the disease or condition causing death.				5-3-50
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)		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 May 3, 1950, to May 3, 1950, that I last saw the deceased alive on May 3, 1950, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE Carl H. Reitz (Degree or title) M.D.	23b. ADDRESS 404 1/2 W. 75th	23c. DATE SIGNED 5-5-50
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 5-6-50	24c. NAME OF CEMETERY OR CREMATORY Forest Hill
24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		

DATE REC'D BY LOCAL REG. 5-5-50	REGISTRAR'S SIGNATURE Heraldine Holmer	25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary, Kansas City, Missouri	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10' block

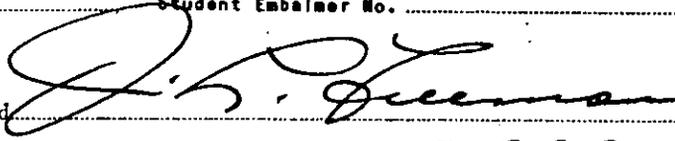
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

.....
Student Embalmer No.

Student
Student Embalmer

Signed 

Licensed Embalmer No. 2939

P. O. Address K. C. 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.