

FILED JUN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17028
2365

BIRTH NO. 29625-50 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) OR TOWN KANSAS CITY		c. LENGTH OF STAY (in this place) 12 Days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		12
d. FULL NAME OF HOSPITAL OR INSTITUTION 3331 TROOST			d. STREET ADDRESS (If rural, give location) 3331 TROOST 330		
3. NAME OF DECEASED (Type or Print) a. (First) SONDRA		b. (Middle) LEA	c. (Last) Zeiler		4. DATE OF DEATH (Month) (Day) (Year) 5 25 50
5. SEX Fcm	6. COLOR OR RACE W	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 05-13-50		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 12 IF UNDER 2 HRS. Days Hours Min.
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) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME RAY EUGENE Zeiler		13b. MOTHER'S MAIDEN NAME Bonnie Lea Bishop		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 RAY EUGENE Zeiler 3331 TROOST		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diarrhea of Newborn	ANTECEDENT CAUSES DUE TO (b) Aspiration Pneumonia				7634
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	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 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)	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 Pathologist, 19, that I last saw the deceased alive on 19, and that death occurred at m, from the causes and on the date stated above.					
23a. SIGNATURE Jack H. Hill (Degree or title)		23b. ADDRESS 3001 Wyandotte St		23c. DATE SIGNED 2 May 50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 5/25/50	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Osceola Mo	
DATE REC'D BY LOCAL REG. 5-25-50		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.P. Sheil K.C. Mo	

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.

Student
Student Embalmer

Signed _____

J. P. Sheil

Licensed Embalmer No. 3625

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.