

FILED JAN 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
1290
Registrar's No.
132

BIRTH NO. 2140-51 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	c. LENGTH OF STAY (in this place) <u>1 year</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> <u>8150</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Trinity Lutheran Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1341 South 26th</u>	

3. NAME OF DECEASED (Type or Print) <u>Rosemarie</u>	a. (First)	b. (Middle)	c. (Last) <u>Salazar</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 4 51</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>1-3-51</u>	9. AGE (in years last birthday) If under 1 year: Months Days <u>3 23</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>John Joe Salazar</u>	13b. MOTHER'S MAIDEN NAME <u>Roberta Core Dellinger</u>	14. NAME OF HUSBAND OR WIFE <u>--</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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Roberta Salazar</u>	ADDRESS <u>1341 South 26th</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>75 min</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Polycystic kidneys + congenital anomalies</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Prematurity -</u> DUE TO (b) <u>7 1/2 months baby -</u> DUE TO (c) <u>lived 20 minutes.</u>		
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"/>
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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)	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 1-3, 1950, to 1-4, 1950, that I last saw the deceased alive on 1-4-51, 1951, and that death occurred at 3:20 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Eugene H. Ferguson M.D.</u> (Degree or title)	23b. ADDRESS <u>933 Prof Bldg</u>	23c. DATE SIGNED <u>1-9-51</u>
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24a. BURIAL CREMATION REMOVAL (Specify) <u>retained</u>	24b. DATE <u>1-4-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Laboratory</u>	24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>1-10-51</u>	REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Trinity Lutheran Hosp.</u>	ADDRESS <u>K.C. Mo.</u>
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(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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.