

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20304**
2377

FILED JUN 23 1951

BIRTH NO. 44604-51 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3119

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. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 4 Days		d. STREET ADDRESS (If rural, give location) 618 West 13th St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Conley Maternity Hospital			

3. NAME OF DECEASED (Type or Print) Loren Raymond Paackard		4. DATE OF DEATH (Month) (Day) (Year) June 2 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH May 30 1951
9. AGE (In years) (If UNDER 1 YEAR last birthday) Months Days Hours Min. 4		11. BIRTHPLACE (State or foreign country) Kansas City, Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Joe Paackard	13b. MOTHER'S MAIDEN NAME Maxine Kimler	14. NAME OF HUSBAND OR WIFE Child
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 Mr Joe Paackard Kansas City, Missouri

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectases		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital deformity of pulmonary arteries & Patent ductus foramen ovale		7543	
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 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 Birth, 19 , to June 2, 1951, that I last saw the deceased alive on June 2, 1951, and that death occurred at 7 A. M. from the causes and on the date stated above.

23a. SIGNATURE E. D. Reese	23b. ADDRESS 2023309 E 12	23c. DATE SIGNED 6-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 4 1951	24c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 6-3-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. C. L. Forster Kansas City, Missouri
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Dean Owens

Licensed Embalmer No. 4280

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.