No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 22 1952

State File No. 8382

BIRTH NO. 14453 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1156

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Trinity Lutheran

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 7911 South Benton

3. NAME OF DECEASED (Type or Print)
a. (First): Infant
b. (Middle):
c. (Last): Hahn

4. DATE OF DEATH (Month) (Day) (Year): 3 9 52

5. SEX: Fe
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 3-9-52
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 15 Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and State or Foreign Country): K. C. Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: George Hahn
13b. MOTHER'S MAIDEN NAME: Mary G. Dalton
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: George Hahn **ADDRESS**: 7911 S. Benton KCMO.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe pre-eclampsia (maternal)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/9, 1952 *to* 3-9, 1952, *that I last saw the deceased alive on* 3/9, 1952, *and that death occurred at* 9 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert F. Lamar MD **(Degree or title)** M.D. **23b. ADDRESS** Professional Bldg **23c. DATE SIGNED** 3/11/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-11-52
24c. NAME OF CEMETERY OR CREMATORY: Greenlawn
24d. LOCATION (City, town, or county) (State): Kandas City Mo.

DATE REC'D BY LOCAL REG.: 3-11-52
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE: Mellody-McGilley-Eylar **ADDRESS**: KCMO.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Lamar
Proj. Bg.

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 Glen E. Heck

Licensed Embalmer No. 4063

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.