

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20413

State File No.

FILED JUL 5 1952 35789

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2672

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) Lifetime		d. STREET ADDRESS (If rural, give location) 1402 Troost	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2			
3. NAME OF DECEASED (Type or Print) a. (First) (Infant) b. (Middle) c. (Last) Dangerfield			4. DATE OF DEATH (Month) (Day) (Year) 5 12 52
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 5-10-52
9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Kansas City, MISSOURI
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? America
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Annie Dangerfield	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 Miss Annie Dangerfield ADDRESS 1402 Troost

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) Premature Macerated Infant		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		7/16x
	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) (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 **5-10-52**, 19___, to **5-12-52**, 19___, that I last saw the deceased alive on **5-12-52**, 19___, and that death occurred at **1:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis MD (Degree or title)	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 5-15-52
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE 6-16-52	24c. NAME OF CEMETERY OR CREMATORY Leeds Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City MO
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DATE REC'D BY LOCAL REG. 6-13-52	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FINER OF DIRECTOR'S SIGNATURE Ann C. Penney MD ADDRESS
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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.....

Not Embalmed

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Wm. A. [Signature]

Signed.....

Student Embalmer

Licensed Embalmer No. *3089*

P. O. Address *150 MD*

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.