

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

DECEASED AUG 4 1952
BIRTH NO. 3541952

REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3075

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) 3 days		d. STREET ADDRESS (If rural, give location) 546 Gillis 3038	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) Lee c. (Last) Anthony Dickinson			4. DATE OF DEATH (Month) (Day) (Year) 1-13-52
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 1-10-52
9. AGE (In years last birthday) 3		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Richard Dienst	13b. MOTHER'S MAIDEN NAME Dickinson Katherine Trombino	14. NAME OF HUSBAND OR WIFE
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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) No	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME KATHERINE DICKINSON	ADDRESS 546 Gillis
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Possible Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7700
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Erythroblastosis Fetalis		
	DUE TO (c)		
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) (Min.)	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 **1-11-52** to **1-13-52**, that I last saw the deceased alive on **1-11-52**, and that death occurred at **2:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURES Sidney F. Pakula MD (Degree or title)	23b. ADDRESS 411 Nichol Rd KC Mo	23c. DATE SIGNED 7-2-52
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	*24b. DATE 7-7-52	24c. NAME OF CEMETERY OR CREMATORY Research Hospital	24d. LOCATION (City, town, or county) (State) Kansas City Missouri
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DATE REC'D BY LOCAL REG. 7-7-52	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE -	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 _____

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.