No. 300
10.48

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

FILED FEB 18 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5959

State File No.

BIRTH NO. 8563 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 297

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): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Conley Maternity Hosp.

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): 519 E 6th 3150

3. NAME OF DECEASED (Type or Print)
a. (First): NORMAN
b. (Middle): RILEY
c. (Last): GUNN

4. DATE OF DEATH (Month) (Day) (Year): 1-16-53

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVER MARRIED
8. DATE OF BIRTH: 1-16-53
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 0 / Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MISSOURI
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: NORMAN RILEY GUNN
13b. MOTHER'S MAIDEN NAME: DOROTHY MARIE GILLETTE
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: Norman Gunn
ADDRESS: 519 E. 6th

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): Unknown — INTERVAL BETWEEN ONSET AND DEATH: 45 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): anoxia due to inadequate respiratory development
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: 759.0

19a. DATE OF OPERATION: NONE
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* 1-16, 1953, *to* 1-16, 1953, *that I last saw the deceased alive on* 1-16, 1953, *and that death occurred at* 5:36 pm., *from the causes and on the date stated above.*

23a. SIGNATURE: W. F. Spiller (Degree or title): DO
23b. ADDRESS: 2603 East 31
23c. DATE SIGNED: 1-18-53

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: Jan 1, 53
24c. NAME OF CEMETERY OR CREMATORY: Forest Hill
24d. LOCATION (City, town, or county) (State): Kansas City Mo

DATE REC'D BY LOCAL REG.: 1-19-53
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE: Mrs C L Forster
ADDRESS: KC Mo

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
c. LENGTH OF STAY (In this place)
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
d. STREET ADDRESS (If rural, give location)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)

5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years last birthday) If under 1 year: Months Days If under 1 hr.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
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)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH

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. _____

Student _____
Student Embalmer

Signed [signature] Licensed Embalmer No. 3599

P. O. Address [signature]

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.

WHITE PLASTIC—ONLY FOR THE PERMANENT RECORD