

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10058

State File No. _____

1247

S. No. 300
V. 10.48

FILED MAR 27 1953

BIRTH NO. 86605 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH Children's Mercy Hospital USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. COUNTY Jackson a. STATE Mo b. COUNTY LaFayette

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City Mo c. LENGTH OF STAY (In this place) 25 days c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Odessa 0540

d. FULL NAME OF HOSPITAL OR INSTITUTION Childrens Mercy Hospital d. STREET ADDRESS (If rural, give location) 417 W. Main

3. NAME OF DECEASED a. (First) Carol Marie b. (Middle) _____ c. (Last) Royers 4. DATE OF DEATH (Month) (Day) (Year) 3 - 1 - 53

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 8. DATE OF BIRTH 12-27-52 9. AGE (In years last birthday) 2 IF UNDER 1 YEAR Months 2 IF UNDER 1 YEAR Days 2 IF UNDER 1 HRS. Hours _____ Mins. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (City and State or Foreign Country) Odessa, Mo 12. COUNTRY OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jack Rogers 13b. MOTHER'S MAIDEN NAME Alma Carsten 14. NAME OF HUSBAND OR WIFE Infant

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 Jack Rogers ADDRESS 417 W. Main Odessa

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angioma congenita.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
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
24 Days
13 1/2 Hrs
7441

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 2-4, 1953, to 3-1, 1953, that I last saw the deceased alive on 3-1, 1953, and that death occurred at 3:14 m., from the causes and on the date stated above.

23a. SIGNATURE H. M. Gilkey (Degree or title) M.D. 23b. ADDRESS 1624 Prof Bldg. 23c. DATE SIGNED _____

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 3-1-53 24c. NAME OF CEMETERY OR CREMATORY _____ 24d. LOCATION (City, town, or county) (State) Springfield Mo.

DATE REC'D BY LOCAL REG. 3-1-53 REGISTRAR'S SIGNATURE Sheraldine Smith 25. FUNERAL DIRECTOR'S SIGNATURE Husman Sparks ADDRESS Odessa, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

Am. J. T. Co.

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.....

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.

as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

rise to the above cause (a) stating the underlying cause last.

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 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 NOT WHILE
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
Removal24b. DATE
Mar. 1, 1953

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)
Springfield, MO.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Husman Sparks Odessa, MO.

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.....
Student Embalmer

Signed

Irving T. Furman

Licensed Embalmer No. *754*

P. O. Address *Adams 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.