

FILED JUN 9 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17910
2654

BIRTH NO. 29017 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1062 Registrar's No.

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) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		3438
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital			d. STREET ADDRESS (If rural, give location) 113 713 E. 30th		
3. NAME OF DECEASED (Type or Print) a. (First) Baby Shirley		b. (Middle) Ann	c. (Last) Bolling	4. DATE OF DEATH (Month) (Day) (Year) 5-24-53	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 5-24-53	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days Hours Mins. 1
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 (City and State or Foreign Country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME Stanley Emmet Bolling		13b. MOTHER'S MAIDEN NAME Leona Madeline Page	14. NAME OF HUSBAND OR WIFE none		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME mother - Leona Bolling		ADDRESS K.C. Mo.
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.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Anoxia			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			7540		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (b) Patent Foramen Ovale		
DUE TO (c) Prematurity					
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 type="checkbox"/> NO <input checked="" 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)		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 5:24, 1953, to 5:24, 1953, that I last saw the deceased alive on 5-24, 1953, and that death occurred at 11:30 A.M., from the causes and on the date stated above.					
23a. SIGNATURE R. L. West (Degree or title)			23b. ADDRESS		23c. DATE SIGNED 5-24-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-24-53	24c. NAME OF CEMETERY OR CREMATORY Laurent Hill	24d. LOCATION (City, town, or county) (State) Adrian Mo		
DATE REC'D BY LOCAL REG. 5-24-53		REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lief Funeral Service Adrian 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

This body Not Embalmed
Adrian Mc

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.