

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18000

State File No. 2665

FILED JUN 9 1953

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

1. PLACE OF DEATH a. COUNTY Jackson CO		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Missouri b. COUNTY Jackson MO	
b. CITY OR TOWN Kansas City, MO	c. LENGTH OF STAY (in this place) 15-MO	c. CITY OR TOWN Kansas City	d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 3178
d. FULL NAME OF HOSPITAL OR INSTITUTION Childrens Mercy Hospital		e. STREET ADDRESS (If rural, give location) 701 Woodlands	

3. NAME OF DECEASED (Type or Print) Donna Jean Eaton		4. DATE OF DEATH (Month) (Day) (Year) May - 24 - 1953	
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Boby O	8. DATE OF BIRTH Feb-14-1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 57
13a. FATHER'S NAME Ben Eaton		13b. MOTHER'S MAIDEN NAME Hunsaker	14. NAME OF HUSBAND OR WIFE None
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 Address Heraldene Hunsaker Eaton, 701 Woodlands, Kansas City, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous Meningitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Tuberculous hilar lymphadenitis DUE TO (c) Pulmonary tuberculosis 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	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	

12. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BIRTHPLACE (City and State or Foreign Country) K.C. General Hospital, K.C. Mo.	
-------------------------------------	--	--	--

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) m.		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 5-12-1953, to 5-24-1953, that I last saw the deceased alive on 5-24-1953, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE H. M. Gilkey (Degree or title) MD		23b. ADDRESS 1624 Prof. Bldg		23c. DATE SIGNED 5-24-1953	
--	--	------------------------------	--	----------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May-26-1953		24c. NAME OF CEMETERY OR CREMATORY Green Lawn		24d. LOCATION (City, town, or county) (State) Kansas City Mo.	
--	--	-----------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG 5-25-53		REGISTRAR'S SIGNATURE Heraldene Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. C. L. Foster K.C. Mo.	
---------------------------------	--	---------------------------------------	--	---	--

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

lymphadenitis

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 359

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.