

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21544

State File No. \_\_\_\_\_

3007

FILED JUL 9 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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 OR TOWN Kansas City  
c. LENGTH OF STAY (In this place) 3 2/3 yrs

c. CITY OR TOWN Kansas City  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION: General Hospital No. 1

e. STREET ADDRESS (If rural, give location) 143 2545 CHERRY 34<sup>30</sup>

3. NAME OF DECEASED  
a. (First) Linda b. (Middle) Marie c. (Last) England

4. DATE OF DEATH (Month) (Day) (Year)  
6-12-53

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED

8. DATE OF BIRTH OCT 2, 1949

9. AGE (In years last birthday) 3

IF UNDER 1 YEAR Months Days IF UNDER 1 MRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) KANSAS CITY MO

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME FRANCIS F. ENGLAND

13b. MOTHER'S MAIDEN NAME ROSE MARIE HACKATHORN

14. NAME OF HUSBAND OR WIFE MRS. FRANCIS F ENGLAND

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 MRS FRANCIS F ENGLAND R.C.M.O ADDRESS 2545 CHERRY

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Heat exhaustion  
  
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. mental deficiency

INTERVAL BETWEEN ONSET AND DEATH  
  
3 25 5

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) (Min.)

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 June 12, 1953, to June 12, 1953, that I last saw the deceased  alive on June 12, 1953, and that death occurred at 8:10 pm., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) 0

23b. ADDRESS 24th & Cherry

23c. DATE SIGNED 6-14-53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 6-15-53

24c. NAME OF CEMETERY OR CREMATORY FORREST HILL

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

DATE REC'D BY LOCAL REG. 6-15-53

REGISTRAR'S SIGNATURE Geraldine Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D.W. NEWCOMERS SONS K.C. MO

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
B. I. BURTS MD

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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 *Basil Malone*.....

Licensed Embalmer No.....

P. O. Address *Collins*.....

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.