S. No. 300
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FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31689

BIRTH NO. 60084 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4405

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

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) Osteopathic Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City Mo
d. STREET ADDRESS (If rural, give location) 2602 Summit 3458

3. NAME OF DECEASED (Type or Print) a. (First) Linda b. (Middle) Kay c. (Last) Blakey

4. DATE OF DEATH (Month) 9 (Day) 8 (Year) 53

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant
8. DATE OF BIRTH 8-25-53
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 14 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F. C. none
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 H. C. Blakey
13b. MOTHER'S MAIDEN NAME Evelyn Perkins
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 H. C. Blakey ADDRESS 2602 Summit

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) atresia of duodenum — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital defect
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intra-ventricular defect — 75 62

19a. DATE OF OPERATION Sept 1, 1953
19b. MAJOR FINDINGS OF OPERATION atresia of duodenum
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 Aug 28, 1953, to Sept 7, 1953, that I last saw the deceased alive on Sept 7, 1953, and that death occurred at 12 30 pm., from the causes and on the date stated above.

23a. SIGNATURE Myron D. Jones (Degree or title) Myron D. Jones D.O.
23b. ADDRESS 926 E 11th St. K.C. 6 Mo.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) removal
24b. DATE 9/10-1953
24c. NAME OF CEMETERY OR CREMATORY Liberty Cem.
24d. LOCATION (City, town, or county) Springfield Mo (State)

DATE REC'D BY LOCAL REG. 9-9-53
REGISTRAR'S SIGNATURE Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE Leo B. Lazetura ADDRESS KC Mo

(Licensed Embalmer's Statement on Reverse Side)

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: Peter B. Georgetown

Licensed Embalmer No. 4273

P. O. Address KC Mo

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.