

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45066

State File No.

FILED JAN 27 1954

BIRTH NO. 51942 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 6192

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | | c. LENGTH OF STAY (In this place) <u>30 hrs 22 min</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> <u>3898</u> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u> | | | d. STREET ADDRESS (If rural, give location) <u>7437 Waldron</u> | | |

| | | | | | |
|--|---------------------------|--------------------------|---------------------|--------------------|-----------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) <u>Brenda</u> | b. (Middle) <u>Mae</u> | c. (Last) <u>Hill</u> | (Month) <u>7</u> | (Day) <u>29</u> | (Year) <u>1953</u> |

| | | | | | | | |
|-------------------------|----------------------------------|--|--------------------------------------|---------------------------------|-----------------|-----------------|-----------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u> | 8. DATE OF BIRTH <u>7-27-1953</u> | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 1 YEAR | IF UNDER 1 YEAR |
| | | | | Months | Days | Hours | Min. |
| | | | | | <u>1</u> | <u>6</u> | <u>22</u> |

| | | | |
|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---|-----------------------------------|--|---|

| | | |
|--|---|-----------------------------|
| 13a. FATHER'S NAME <u>Robert Phillip Hill</u> | 13b. MOTHER'S MAIDEN NAME <u>Doris Mae Burnard</u> | 14. NAME OF HUSBAND OR WIFE |
|--|---|-----------------------------|

| | | | |
|---|-------------------------------------|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>—</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. R.P. Hill</u> | ADDRESS <u>7437 Waldron R.C. Mo.</u> |
|---|-------------------------------------|--|---|

| | | | |
|---|--|------------|----------------------------------|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarct</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) 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. | | <u>not</u> | |

| | | |
|------------------------|----------------------------------|---|
| 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) (Min.) | 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 7-27, 1953, to 7-29, 1953, that I last saw the deceased alive on 7-29, 1953, and that death occurred at 12:58 A.M., from the causes and on the date stated above.

| | | |
|--|---------------------------------------|------------------|
| 23a. SIGNATURE (Degree or title) <u>Richard B. Schurz</u> | 23b. ADDRESS <u>411 North 10th</u> | 23c. DATE SIGNED |
|--|---------------------------------------|------------------|

| | | | |
|---|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 24b. DATE <u>7-31-53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Hospital</u> | 24d. LOCATION (City, town, or county) (State) <u>444 J.C. Nichols R.C. Mo.</u> |
|---|-----------------------------|--|---|

| | | | |
|---|--|---|---------------------------|
| DATE REC'D BY LOCAL REG <u>1-18-54</u> | REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Luke's Hosp.</u> | ADDRESS <u>A-C Mo.</u> |
|---|--|---|---------------------------|

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

1919

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.