

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45116

State File No.

6141

FILED JAN 22 1954

BIRTH NO. 71018 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 (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Conley Maternity Hospital		d. STREET ADDRESS (If rural, give location) 2107 East Front St.	

3. NAME OF DECEASED (Type or Print) a. (First) SHIRLINE	b. (Middle) KAY	c. (Last) TODD	4. DATE OF DEATH (Month) (Day) (Year) 11 - 21 - 53
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 10-17-53
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY U. S.			

13a. FATHER'S NAME Harold Homer Todd	13b. MOTHER'S MAIDEN NAME Georgia Eleanor McGuire	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY (If yes, give war or dates of service) no	17. INFORMANT'S SIGNATURE OR NAME Georgia Todd	ADDRESS 2107 E. Front St.
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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		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUPLICATE Congenital Malformations hydrocephalus and spina bifida		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			490K

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 10-17, 1953, to 11-21, 1953, that I last saw the deceased alive on 11-21, 1953, and that death occurred at 12:30 AM. from the causes and on the date stated above.

23a. SIGNATURE Luther W. Swift	(Degree or title) DO 2	23b. ADDRESS 2105 Indep. Ave	23c. DATE SIGNED 11-21-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal for scientific study at K. C. College of Osteopathy and Surgery	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 12-30-53	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE K. C. College of Osteopathy	ADDRESS K. C. Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Mr 0383,

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. . . .