

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1459**

FILED JAN 27 1954

BIRTH NO. 59445-5-3 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1609 Registrar's No. 175

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) Kansas City		c. LENGTH OF STAY (In this place) 6 weeks	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Cheryl b. (Middle) Lea c. (Last) Narron		4. DATE OF DEATH (Month) (Day) (Year) 1 11 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH 12-1-53
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (City and State or Foreign Country) K.C. Mo.
13a. FATHER'S NAME Wallace Narron		13b. MOTHER'S MAIDEN NAME Dorothy Schaller	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 Wallace Narron ADDRESS Same
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Congenital anomaly of brain + skull.	
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.)	
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 Dec. 1, 1953 , to Jan. 11, 1954 , that I last saw the deceased alive on Jan. 11, 1954 , and that death occurred at 7:50A m. , from the causes and on the date stated above.			
23a. SIGNATURE B.I. Burns (Degree or title) M.D.		23b. ADDRESS 24th & Cherry	
23c. DATE SIGNED 1-11-54		24. LOCATION (City, town, or county) (State) Kansas City Kan.	
24a. BIRTH REMOVAL (Specify)	24b. DATE 1-12-54	24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	24d. LOCATION (City, town, or county) (State) Kansas City Kan.
DATE REC'D BY LOCAL REG. 1-12-54	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE D.E. Weikel ADDRESS K.C. Mo.	

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

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..... *D. E. Weelut*

Licensed Embalmer No. *407*

P. O. Address *K.C. 87*

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.