

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **15853**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1281</u>			
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		c. LENGTH OF STAY (In this place) 2 hours		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Hospital				STREET ADDRESS (If rural, give location) 716 West 38th Street 3488					
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) T. c. (Last) DOOHAN, Jr.			4. DATE OF DEATH (Month) (Day) (Year) May 2, 1954						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) mm single		8. DATE OF BIRTH 5-2-54			
9. AGE (In years last birthday) _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri			
11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? USA							
13a. FATHER'S NAME Wm. T. Doochan			13b. MOTHER'S MAIDEN NAME Janet Anderson		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 ADDRESS W. T. Doochan, 716 W. 38th, K. C., Mo.					
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) HYDROCEPHALUS-APLASTIC KIDNEYS ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CONGENITAL DEFECTS DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7513	
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) KANSAS CITY JACKSON MO					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? CONGENITAL DEFECT					
22. I hereby certify that I attended the deceased from <u>5/2</u> , 19 <u>54</u> , to <u>5/2</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5:30 PM 5/19/54</u> , and that death occurred at <u>5:05 PM</u> m., from the causes and on the date stated above.									
23a. SIGNATURE D. T. Van Del (Dr. or title) MD MD				23b. ADDRESS 1103 GRAND-909		23c. DATE SIGNED 5/3/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-3-54		24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri			
DATE REC'D BY LOCAL REG. 5-3-54		REGISTRAR'S SIGNATURE Seraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-MoGilley-Eylar, Kansas City, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

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

Van Ness - Reg.

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.....
Licensed Embalmer No.....
P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.**