

FILED JUL 12 1954

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19061**

BIRTH NO. **42744-54** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1602** Registrar's No. **2708**

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) 15 min		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		d. STREET ADDRESS (If rural, give location) 3438 2805 Charlotte	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital			3. NAME OF DECEASED a. (First) Infant b. (Middle) Matthews c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 6-15-54	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 6-15-54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Johnny Claude Matthews			13b. MOTHER'S MAIDEN NAME Marghville Robertson			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) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mr. Johnny Matthews ADDRESS 2805 Charlotte			
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) 22 weeks premature ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. met				INTERVAL BETWEEN ONSET AND DEATH 15 min	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 9:30 a.m. 6/15/54 to 6/15/54 , that I last saw the deceased alive on 6/15/54 , and that death occurred at 9:35 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Typed or title) Joseph P. Smith M.D.				23b. ADDRESS 1103 Grand Ave		23c. DATE SIGNED 6/15/54	
24a. BURIAL, CREMATION REMOVAL (Specify) Removal		24b. DATE 6/16/54		24c. NAME OF CEMETERY OR CREMATORY Humanville		24d. LOCATION (City, town, or county) (State) Humanville Mo	
DATE REC'D BY LOCAL REG. 6-16-54		REGISTRAR'S SIGNATURE Heraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE John P. Shel ADDRESS N.C. Mo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Joseph C. Webster

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 _____

John P. Shiel

Licensed Embalmer No. 2625

P. O. Address K C Rd

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.