

FILED JUL 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22911

BIRTH NO. 42923-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2932

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) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>	c. CITY OR TOWN <u>Kansas City</u>		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 <u>St. Mary's Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>7315 East 40 Highway</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael</u> b. (Middle) <u>Anthony</u> c. (Last) <u>Sack</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-28-1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>6-27-'54</u>		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) <u>- - - 23 50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>James Valentine Sack</u>		13b. MOTHER'S MAIDEN NAME <u> Dorothy Ann Lang</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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.	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. James V. Sack</u>		
				ADDRESS <u>7315 East 40 Highway</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, asphyxia, 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>atelectasis with anoxia</u>			<u>Partial premature separation of placenta</u>			<u>24 hrs</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (b) <u>mother fed 16 hrs before acute onset</u>			<u>34 hrs</u>
DUE TO (c) <u>Baby 7 month premature</u>						<u>76 2/5</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Autopsy: - atelectasis Petechial hemorrhages of brain, lungs + heart</u>		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)	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 6-27, 1954 to 6-28, 1954 that I last saw the deceased alive on 6-28, 1954 and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Leo A. O'Brien</u> (Degree or title) <u>Leo A. O'Brien M.D. MD</u>		23b. ADDRESS <u>1002 aryle 306 E 12 N.C. Mo</u>		23c. DATE SIGNED <u>6-29-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>6-29-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>-</u>	24d. LOCATION (City, town, or county) (State) <u>Pilot Grove, Mo.</u>		

DATE REC'D BY LOCAL REG. <u>6-29-54</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hayer + Painter, Pilot Grove, Mo.</u>		
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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.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.