

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34086

State File No. ....

4721

BIRTH NO. 4707 30539-54 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 MO b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place)  
Kansas City 5 1/2 Mon. d. CITY OR TOWN Kansas City e. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St Mary's Hospital f. STREET ADDRESS (If rural, give location) 3435 E 6th St 3188

3. NAME OF DECEASED (Type or Print) a. (First) Linda b. (Middle) Sue c. (Last) Pierce 4. DATE OF DEATH (Month) (Day) (Year) 10-9-54

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never Married 8. DATE OF BIRTH 4-28-54 9. AGE (in years last birthday) IF UNDER 1 YEAR Months 5 Days 11 IF UNDER 11 HRS. Hours  Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and State or Foreign Country) Kansas City MO 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Raginald Pierce 13b. MOTHER'S MAIDEN NAME Mary Gamble 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) None 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Raginald Pierce ADDRESS 3435 E 6th St

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
None  
\*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) Hydrocephaly, Intereath Congenital 5 1/2 Nos.  
(b) Spina Bifida, Sacral, Cong. 5 1/2 Nos.  
(c) Anoxemia Respiratory Failure 2hrs.  
II. OTHER SIGNIFICANT CONDITIONS due to central depression Hemorrhage cerebral ventricles 7 1/2 hrs

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION Spina Bifida + Myelomeningocele Repaired 5 1/2 hrs 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) None

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from 4-28-1954 to 10-9-1954, that I last saw the deceased alive on 10-9-1954, and that death occurred at 1 P.M., from the causes and on the date stated above.

23a. SIGNATURE Harold A. Bucks (Degree or title) 0 23b. ADDRESS 1019-23 ARBUE Bldg. 23c. DATE SIGNED 10-10-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 10-11-54 24c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's Cemetery 24d. LOCATION (City, town, or county) (State) Kansas City MO

DATE REC'D BY LOCAL REG. 10-10-54 REGISTRAR'S SIGNATURE neva minshall 25. FUNERAL DIRECTOR'S SIGNATURE Passantino Bros 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 *Francis Walter*.....

Licensed Embalmer No. *274*

P. O. Address *16 C Mo.*

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.