

FILED NOV 5 - 1954

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

 State File No. **34193**  
**4833**

 BIRTH NO. **70359-54** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived) Institution: residence before admission. a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. LENGTH OF STAY (If this place) <b>Life</b>	c. CITY OR TOWN <b>Kansas City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>			STREET ADDRESS (If rural, give location) <b>1205 W. 69th. P. 2850</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Infant</b> b. (Middle) c. (Last) <b>TRAXLER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10-8-54</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>0</b>	8. DATE OF BIRTH <b>10-8-54</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Seymour Dean Traxler</b>		13b. MOTHER'S MAIDEN NAME <b>Sylvia Lee Kaufman</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Seymour Dean Traxler N.C. Mo.</b>		
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) <b>Premature - 22 wks</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Premature rupture of membranes</b>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <b>776 K</b>		
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 <b>10-8-54</b> , 19 <b>54</b> , to <b>10-8-54</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>10-8</b> , 19 <b>54</b> , and that death occurred at <b>9:15</b> p.m., from the causes and on the date stated above.					
23a. SIGNATURE OF REGISTRAR <b>F. E. Baum</b> (Degree or title) <b>MD</b>			23b. ADDRESS <b>701 E. 63rd</b>		23c. DATE SIGNED <b>10-8-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>10-15-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Baby retained by Menorah Medical Center</b>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <b>10-18-54</b>	REGISTRAR'S SIGNATURE <b>new mind</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>scientific research</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

76-8300

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.

initial