

FILED JUL 1 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18923**
Registrar's No. **2566**

BIRTH NO. **448023278-55** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Kansas b. COUNTY WYANDOTT Johnson	
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City		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 Conley Maternity Hospital		e. STREET ADDRESS (If rural, give location) 2011 Baby	
3. NAME OF DECEASED a. (First) PAULA b. (Middle) DIANE c. (Last) RIEDL		4. DATE OF DEATH (Month) (Day) (Year) 4 - 4 - 55	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 4-3-55
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Michael Thomas Riedl		13b. MOTHER'S MAIDEN NAME Bessie Kathleen Smittle	14. NAME OF HUSBAND OR WIFE -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Bessie T. Riedl ADDRESS 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis ANTECEDENT CAUSES DUE TO (b) Intra-uterine anoxia DUE TO (c) Cord Impingement 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	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7610	
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 April 3, 1955 , to April 4, 1955 , that I last saw the deceased alive on April 4, 1955 , and that death occurred at 2:20 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Arthur W. Swift (Degree or title)		23b. ADDRESS 2105 Independence Ave.	23c. DATE SIGNED 4-4-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Destroyed at	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY Conley Maternity Hospital	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
DATE REC'D BY LOCAL REG. 6-15-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Conley Maternity Hosp. K.C. Mo. ADDRESS	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Luther W. Swift

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.