

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33274**  
**4177**

FILED OCT 19 1955

BIRTH NO. **76388-55** 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. If 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. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>life</b>		STREET ADDRESS (If rural, give location) <b>45 2550 Summit 3450</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital No. 1</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Inf</b> b. (Middle) _____ c. (Last) <b>Herndon</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>9 7 1955</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>9-2-1955</b>	9. AGE (In years last birthday) _____	10. UNDER 1 YEAR Months _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		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>Robert F. Herndon</b>	13b. MOTHER'S MAIDEN NAME <b>Dorma James</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. <b>none</b>
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Record Librarian K.C. Gen'l Hosp. #1</b>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary atelectasis</b>		DUE TO (b) <b>Congenital polycystic disease of kidney</b>		<b>7571.</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		
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"/>
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 **Sept. 9, 1955**, to **Sept. 9, 1955**, that I last saw the deceased alive on **Sept. 9, 1955**, and that death occurred at **5:50A. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>B. I. Burns, M.D.</b>	B. I. Burns (Degree or title)	23b. ADDRESS <b>21th &amp; Cherry</b>	23c. DATE SIGNED <b>9-7-1955</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>	24b. DATE <b>9-27-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Leeds</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City MO</b>

DATE REC'D BY LOCAL REG. <b>9-27-55</b>	REGISTRAR'S SIGNATURE <b>newa minshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Thos A. Schuyler 1700 7th</b>
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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 Not Embalmed, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... Wm. A. St. Pierre

Licensed Embalmer No. 30

P. O. Address 150

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.