

FILED MAR 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH43538  
State File No. ....BIRTH NO. 16408 97318-55 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1110

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 (If this place) <b>Life</b>		e. STREET ADDRESS (If rural, give location) <b>2026 E 19th Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital #2</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>(Infant) #1</b> b. (Middle) c. (Last) <b>Haney</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12 27 1955</b>	
5. SEX <b>2</b> <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>12-27-55</b>
9. AGE (In years last birthday) <b>7</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days <b>50</b>
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>America</b>

13a. FATHER'S NAME <b>Paul Haney</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Mae Lollis</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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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 <b>Annie Mae Haney, 2026 E. 19th St.</b>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH  <b>76<sup>25</sup></b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prematurity.</b>		
	ANTECEDENT CAUSES <b>Pulmonary atelectasis.</b>		
DUE TO (b) _____			
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"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 12-27-55, 1955, to 12-27-55, 1955, that I last saw the deceased alive on 12-27-55, 1955, and that death occurred at 4:50 Pm., from the causes and on the date stated above.

23a. SIGNATURE <b>W. H. Bryan M.D.</b>	W. H. Bryan (Degree or title)	23b. ADDRESS <b>600 East 22nd Street</b>	23c. DATE SIGNED <b>12-31-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>3-14-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fields</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>
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DATE REC'D BY LOCAL REG. <b>3-13-56</b>	REGISTRAR'S SIGNATURE <b>neva minshall</b>	25. FEDERAL DIRECTOR'S SIGNATURE <b>W. H. Bryan M.D.</b>	ADDRESS <b>St. Louis MO</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 Mat Embalmed, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Anna L. Schuyler.....

Licensed Embalmer No. 30.....

P. O. Address Ac.....

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.