

STANDARD CERTIFICATE OF DEATH

State File No. **20447**
2612FILED JUL 5 1956
BIRTH NO. **62837853-56** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **2612**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 10 minutes		d. STREET ADDRESS (If rural, give location) 1201 A Brush Creek	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) Ray c. (Last) Cline			4. DATE OF DEATH (Month) (Day) (Year) 5 31 56		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, <input type="checkbox"/> WIDOWED, DIVORCED (Specify) never married	
8. DATE OF BIRTH 5-31-56			9. AGE (In years last birthday) 0		10. UNDER 1 YEAR 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Donald William Cline		13b. MOTHER'S MAIDEN NAME Roth Bacher		14. NAME OF HUSBAND OR WIFE none	
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 Mrs. Donald Cline ADDRESS 1201 A Brush Creek	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) CONGENITAL ABSENCE OF LEFT DIAPHRAGM		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) congenital absence of left diaphragm		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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"/>	
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 **5-31-56**, to **5-31-56**, that I last saw the deceased alive on **5-31-56**, and that death occurred at **3:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. J. Parnsworth (Degree or title) MD		23b. ADDRESS 1103 Grand N.C. Mo.		23c. DATE SIGNED 6/7/56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-1-56		24c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Laboratory	
24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Trinity Lutheran Hosp. K.C. Mo. ADDRESS			
DATE REC'D BY LOCAL REG. 6-14-56		REGISTRAR'S SIGNATURE Neva Minshall			

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
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 this body is not embalmed, fact should be so stated above.