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THE DIVISION OF HEALTH OF MISSOURI

FILED JUL 5 1956 STANDARD CERTIFICATE OF DEATH

State File No. 20697

BIRTH NO. 5823 38776-56 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2704

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) OR TOWN Kansas City

c. CITY OR TOWN Kansas City

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital

e. STREET ADDRESS (If rural, give location) 3517 Wyandotte 34880

3. NAME OF DECEASED (Type or Print)  
a. (First) Infant JOHN b. (Middle) MICHAEL c. (Last) SANDERS

4. DATE OF DEATH (Month) (Day) (Year)  
6 17 56

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH May 21, 1956

9. AGE (In years last birthday) IF UNDER 1 YEAR Months 27 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (City and State or Foreign Country) Kansas city, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Gilbert Sanders

13b. MOTHER'S MAIDEN NAME Geraldine Eldringhoff

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gilbert Sanders-3517 Wyandotte-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) Prematurity  
  
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.

INTERVAL BETWEEN ONSET AND DEATH  
  
776X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from 5-21, 1956, to 6-17, 1956, that I last saw the deceased alive on 6-17, 1956, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE Robert C. Buckner (Degree or title) M.D.

23b. ADDRESS 4620 Nichols Pkwy

23c. DATE SIGNED 6-19-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6/20/56

24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

24d. LOCATION (City, town, or county) (State) Kansas City, Missouri

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 6-20-56 Nevada Marshall

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mellody-McGilley-Eylar-Kansas City, Mo.

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

DR Knock  
written 2 PM - Tu

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. 298

P. O. Address K C W

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.