

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23935

State File No. ....

3115

BIRTH NO. 51873-56 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) <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>20 hrs.</b>		STREET ADDRESS (If rural, give location) <b>920 Newton St., 2208</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Conley Maternity Hospital</b>			
3. NAME OF DECEASED a. (First) <b>RICHARD</b>		b. (Middle) <b>WILLIAM</b>	
		c. (Last) <b>RODGERS</b>	
4. DATE OF DEATH <b>5 - 31 - 56</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>5 - 30 - 56</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Mins. <b>20   5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13a. FATHER'S NAME <b>Lawrence Oliver Rodgers</b>		13b. MOTHER'S MAIDEN NAME <b>Patricia Lorraine Mills</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Lawrence Oliver Rodgers</b>		ADDRESS	
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) <b>Congestive pulmonary disease</b>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Resorption atelectasis</b>	
		DUE TO (c) <b>Hyaline membrane</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>527.2</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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 <b>May 30, 1956</b> , to <b>May 31, 1956</b> , that I last saw the deceased alive on <b>May 31, 1956</b> , and that death occurred at <b>1:40 A. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>R. H. Boyd, Jr.</b> (Degree or title) <b>D.O.</b>		23b. ADDRESS <b>9529 Juniper Rd Indpls Mo</b>	
23c. DATE SIGNED <b>5/31/56</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Destroyed at the Conley Hospital Laboratory</b>		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY <b>Kansas City, Mo.</b>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <b>7-18-56</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Conley Hosp. K.C. Mo.</b>		ADDRESS	

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

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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.