

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27099

State File No.

FILED SEP 11 1956

46048-53

BIRTH NO. 7457 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3565

1. PLACE OF DEATH a. COUNTY <u>Johnson Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If participation: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City, Mo.</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>7th 21 mo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		STREET ADDRESS (If rural, give location) <u>2804 W 77th</u>	
3. NAME OF DECEASED a. (First) <u>Bady</u> b. (Middle) <u>Boy</u> c. (Last) <u>Proctor</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6 22 56</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>6-22-56</u>	
9. AGE (in years last birthday) <u>7 2 1/2</u>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Robert Proctor</u>		13b. MOTHER'S MAIDEN NAME <u>Wells, Margaret A.</u>	
14. NAME OF HUSBAND OR WIFE <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret W. Proctor</u> ADDRESS <u>2804 W. 77th</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>-</u> 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"/>		INTERVAL BETWEEN ONSET AND DEATH <u>at birth</u> <u>76 2/3</u>	
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 <u>6-22-56</u> , to <u>6-22-56</u> , that I last saw the deceased alive on <u>6-22-56</u> , and that death occurred at <u>5:23</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John R. Patterson M.D.</u>		23b. ADDRESS <u>411 Nichols Road KC Mo</u>	
23c. DATE SIGNED <u>6-23-56</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburied</u>		24b. DATE <u>8-14-56</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Hearts of Iron</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-14-56</u>		REGISTRAR'S SIGNATURE <u>Nevas Minsdall</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Janis M. Gibson M.D.</u>		ADDRESS <u>St. Luke Hosp.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
John R. Patterson

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..

Hospital Disposal

Student.....
Signature of Student Embalmer

Signed *David M. Gibson M.D.*
St. Luke's Hospital
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.