

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **30601**
3817

FILED SEP 21 1956

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Kansas City, Mo.</u> (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (in this place) <u>25 Days</u>		c. CITY OR TOWN <u>Kansas City</u> d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>3158</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Children's Mercy Hospital</u>		STREET ADDRESS (If rural give location) <u>15 807 7 crest</u>	

3. NAME OF DECEASED (Type or Print) <u>James Nicholson Bone</u> a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>8 30 56</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	
8. DATE OF BIRTH <u>5-2-56</u>		9. AGE (In years last birthday) <u>3</u>		10. UNDER 1 YEAR <u>28</u> Days	
11. BIRTHPLACE (City and State or Foreign Country) <u>Dreamsbaw, Georgia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>James Bone</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Lou Jones</u>		15. NAME OF HUSBAND OR WIFE <u>none</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
17. SOCIAL SECURITY NO. <u>none</u>		18. INFORMANT'S SIGNATURE OR NAME <u>James Bone</u>		19. ADDRESS <u>807 7 crest, K.C. Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		10c. CAUSE OF DEATH	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pneumonia Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>491 X</u>	
		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)		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 8-5-, 1956, to 8-30-, 1956, that I last saw the deceased alive on 8-30-, 1956, and that death occurred at 11⁰⁰ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wayne Hart</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>1710 Indep. Ave. K.C. Mo.</u>		23c. DATE SIGNED <u>8-30-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>August 31-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Washington</u>	
24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. C.L. Forster</u>		ADDRESS <u>Funeral Home Kansas City Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-31-56</u>		REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

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

Student.....
Signature of Student Embalmer

Signed *J. Miguel Hernandez*
Licensed Embalmer No. *5599*
Address *A. C. M.*

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.