

Health, Welfare, Public Service, 300, 1-56, diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34138

STATE FILE NUMBER

81943-56

FILED OCT 24 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4205

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, give TOWNSHIP only) OR TOWN Kansas City Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rural Jackson Co, Mo		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Mary's		Length of stay in lb 1 hr	d. STREET ADDRESS 9400 Walnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Patricia Middle ann Last Minor			4. DATE OF DEATH Month 10 Day 2 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-56	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 1 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, open if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Baby	11. BIRTHPLACE (City and state or country) Kansas City Mo		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Clyde H Minor			14. MOTHER'S MAIDEN NAME Mildred Cowan		
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 Address Clyde H Minor 9400 Walnut St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure					INTERVAL BETWEEN ONSET AND DEATH 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) atelectasis of lungs					
DUE TO (c) Congenital Deformity					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 11:25 AM Month 10 Day 2 Year 1956 a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from Oct 2, 1956 to Oct 2, 1956 and last saw her him alive on Oct 2, 1956 Death occurred at 11:25 AM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Orval T. Needels M.D.			22b. ADDRESS 7400 Wornall Ave, Mo		22c. DATE SIGNED Oct 3, 1956
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-4-1956	23c. NAME OF CEMETERY OR CREMATORY Black Fox Cemetery		23d. LOCATION (City, town, or county) (State) Near Pierce City Mo	
24. FUNERAL DIRECTOR France-Wornall Funeral Home KC Mo		25. DATE RECD. BY LOCAL REG. 10-3-56	26. REGISTRAR'S SIGNATURE Neve Minshall		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Orval T. Needels, M.D.
MEDICAL CERTIFICATION

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 *Russell N. Fran*.....

Licensed Embalmer No. *43*.....

P. O. Address *K.C.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.