

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1233

STATE FILE NUMBER

FILED JAN 22 1957

6635-57

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 79

Health, Welfare, Public Service  
000-56  
Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on certificate. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Lee's Summit</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LAKE SIDE</b>			Length of stay in 1b <b>9 HOURS</b>	d. STREET ADDRESS (If outside, give location) <b>Lee's Summit</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>CHILES</b> Last <b>CHILES</b>				4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-57</b>		9. AGE (In years last birthday) <b>9 MONTHS</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>KANSAS CITY MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES WALTER CHILES</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE ELIZABETH BUNGE</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 <b>Louise E. Chiles</b> Address <b>Lee's Summit</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) <b>Placenta Previa</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <b>rupt</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 HOURS</b> <b>9 HOURS</b> <b>6 MONTHS</b>
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 type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 a. m. <b>5:40</b> p. m.							
20d. INJURY OCCURRED WHILE AT <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 <b>1-6-57</b> to <b>1-7-57</b> and last saw her <b>her</b> alive on <b>1-6-57</b> Death occurred at <b>5:40 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John M. Howard</b> (Print name or title)				22b. ADDRESS <b>Wasson Kansas 5906 Woodson Road</b>		22c. DATE SIGNED <b>1-7-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)
<b>Cremation</b>		<b>1-10-57</b>	<b>Edgewood Cemetery</b>		<b>K.C. Mo</b>		
24. GENERAL DIRECTOR ADDRESS <b>Wasson Kansas K.C. Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>1-8-57</b>		26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b>	

(Licensed Embalmer's Statement on Reverse Side)

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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. (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.