

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4596

STATE FILE NUMBER

400

FILED FEB 18 1957

6571-57

Registration District No. 149

149

Primary Registration District No. 1002

Registrar's No.

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually 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 Jackson		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City Mo. 3208	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS 7509 East 50th st. K.C. 298	
3. NAME OF DECEASED (Type or print) First Winnie Middle Earlene Last Britton		4. DATE OF DEATH Month January Day 25 Year 1957	
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 January 25-1957
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>infant</i>		11. BIRTHPLACE (City and state or country) Kansas City Missouri	
13. FATHER'S NAME Elba Earl Britton		14. MOTHER'S MAIDEN NAME Arzelda McDaneld	
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 Elba Earl Britton		Address 7509 East 50th 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) <i>respiratory failure</i> DUE TO (b) <i>decompression of intracranial fluid</i> DUE TO (c) <i>hydrocephalus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 1 hr. 752 X
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 _____ Month _____ Day _____ Year _____ 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 1-25-57 to 1-25-57 and last saw her him alive on 1-25-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Walter R. King (Degree or title) <i>Walter R. King, M.D.</i>		22b. ADDRESS 1032 Professional Bldg, K.C., Mo.	
22c. DATE SIGNED 1-26-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE January 26-1957	
23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR ADDRESS Mrs. C.L. Forster Funeral Home K.C. Mo.		25. DATE RECD. BY LOCAL REG. 1-27-57	
26. REGISTRAR'S SIGNATURE Neva Marshall			

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 *John V. Herrick*.....
Licensed Embalmer No. 482
P. O. Address *J. V. Herrick*.....

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.