

FILED MAR 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4853
STATE FILE NUMBER

0 7073-59 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 662

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Downtown Day 2 Weeks		d. STREET ADDRESS 347 N. Hardisty	

3. NAME OF DECEASED (Type or print) First Middle Last BABY JOE EDWARD McLAUGHLIN			4. DATE OF DEATH Month Day Year 2-10-1957		
5. SEX MALE	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 2-8-1957		9. AGE (In years last birthday) 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NO	11. BIRTHPLACE (City and state or country) KANSAS CITY, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME TRACY L. McLAUGHLIN	14. MOTHER'S MAIDEN NAME RITA ANN NEUMANN
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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 Mrs. Marguerite McLaughlin 347 N. Hardisty
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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 DUE TO (b) CONGENITAL ATELECTASIS DUE TO (c) OR POSS. HYALINE MEMBRANE DISEASE 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"/>
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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 2-8-57 to 2-10-57 and last saw her alive on 2-9-57 Death occurred at 2-10-1957 4A.m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Milton Dodge, M.D.	22b. ADDRESS 701 E. 63rd ST.	22c. DATE SIGNED 2-10-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-11-57	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY KC Mo	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR (Name and address) [Signature]	25. DATE RECD. BY LOCAL REG. 2-11-57	26. REGISTRAR'S SIGNATURE Vera Marshall	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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
Milton Dodge

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.....
Robert B. Negret

Licensed Embalmer No. *47*

P. O. Address *KEM*

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.