

health, Welfare public service
300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8809

STATE FILE NUMBER

FILED APR 2 - 1957

1996 15144-57 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1265

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 Kansas City, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital				Length of stay in 12 hr. 55 min.		d. STREET ADDRESS 53 27 Cleveland		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Julia BABY-GIRL Deanne MOORE				First Julia Middle BABY-GIRL Last MOORE		4. DATE OF DEATH Month 2 Day 26 Year 57		
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 2-25-57		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 12 Days 12 Hours 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City, Jackson Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. Frederick Moore				14. MOTHER'S MAIDEN NAME Bettie Darlene Antone				
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 R. Guillot, R.N. St. Luke's Hosp.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Congenital heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH LIVED 12 7 hrs. 7544.	
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 _____ 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 2-25-57 to 2-26-57 and last saw her ^{her} alive on 5 p.m. 2-25-57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) J. Milton Singleton M.D.				22b. ADDRESS 411 Nichols Rd.		22c. DATE SIGNED 2-26-57		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Retained		23b. DATE Feb. 26-57	23c. NAME OF CEMETERY OR CREMATORY Hospital Disposal			23d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
24. FUNERAL DIRECTOR'S NAME AND ADDRESS D. W. Gibson M.D. St. Luke's Hospital				25. DATE RECD. BY LOCAL REG. 3-18-57		26. REGISTRAR'S SIGNATURE Newa Minshall		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
J. Milt on Singleton

no. 25411

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
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.

diseases in Part I must be causally related. Coroner cannot certify that any other diseases in Part I must be causally related. Coroner cannot certify that any other diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITER

18. CAUSE OF DEATH - [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Heart Disease</u>			<u>13 + hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Heart failure</u>		
			DUE TO (c) _____		
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 _____ a. m. _____ p. m. _____			<u>new record 3-18-57</u>		
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 <u>3-20</u>	COUNTY _____	STATE _____
21. I attended the deceased from <u>2/25/57</u> to <u>2/26/57</u> and last saw her him alive on <u>5 PM 2/25/57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>George Herrman MD</u>		(Degree or title)	22b. ADDRESS <u>411 Nichols Rd</u>	22c. DATE SIGNED <u>2/26/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-26-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hospital Disposal St. Lukes - K - c - mo.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>Dr. Gibson Pathologist</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-18-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

St. Luke's Hospital

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..

Hospital Disposal

Student.....
Signature of Student Embalmer

Signed..... *James M. Gelvani M.D.*
St. Luke's Hospital
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.

*# 8809
(1957)*