

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 16 1957

STATE FILE NUMBER
1493

2977 14733-57 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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 Kansas City TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.		Length of stay in lb 17 days	d. STREET ADDRESS (If outside, give location) 1630 Jarboe Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First TIMOTHY Middle LEE Last HOLLIFIELD			4. DATE OF DEATH Month March Day 30 Year 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 March 13, 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.	
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, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jeff Davis Hollifield			14. MOTHER'S MAIDEN NAME Kathleen Boggess		
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 Jeff Davis Hollifield-1630 Jarboe		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity		INTERVAL BETWEEN ONSET AND DEATH since birth 7:035
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) + Bronchopneumonia	
	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.		
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 **March 27, 1957** to **March 30, 1957** and last saw ^{her} ~~him~~ alive on **March 29, 1957**.
Death occurred at **7 AM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Jacqueline M. Baumeister M.D.** 22b. ADDRESS **6509 Prospect** 22c. DATE SIGNED **3/30/57**

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/31/57	23c. NAME OF CEMETERY OR CREMATORY Okay, Oklahoma Cemetery	23d. LOCATION (City, town, or county) (State) Okay, Oklahoma
24. FUNERAL DIRECTOR ADDRESS QUIRK & TOBIN-20 W. Linwood, K.C.Mo.		25. DATE RECD. BY LOCAL REG. 3-30-57	26. REGISTRAR'S SIGNATURE Hloa Minshall

Health, Welfare Public Service
300 1-56
All 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
Jacqueline M. Baumeister

transcript

X

FROM THE

ART

KP
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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 *William M. Turner*

Licensed Embalmer No. *469*
20 26 Lenox
P.O. Address.....
Kansas City, Mo.

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