

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318891  
STATE FILE NUMBER  
4066

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 4066

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hosp.</u>			Length of stay in lb. <u>Life</u>		d. STREET ADDRESS (If outside, give location) <u>203 N. Clinton Place</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>HANES</u>				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>57</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/29/57</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>William R. HANES</u>			13b. MOTHER'S MAIDEN NAME <u>Phyllis M. Duncan</u>			14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>William R. HANES 203 N. Clinton Place</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline membrane of Lungs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Prematurity</u>		DUE TO (c)		774X					
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 <u>6</u> Month <u>8</u> Day <u>29</u> Year <u>57</u> p.m.											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson Mo</u>		COUNTY		STATE		
21. I attended the deceased from <u>8-29-57</u> to <u>8-30-57</u> and last saw her alive on <u>8-30-57</u> Death occurred at <u>4:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>K. L. Shireman</u> (Degree or title)				22b. ADDRESS <u>4606 St John Kemo</u>				22c. DATE SIGNED <u>8-30-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/31/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City, town, or county) <u>Kansas City Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u>			ADDRESS <u>K.C. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-31-57</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

K. L. Shireman



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 *Richard E. Carroll* .....

Licensed Embalmer No. *4829* .....

P. O. Address *R.C. ...* .....

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.