

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **3994**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3994

300
1-57

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		4. STREET ADDRESS 3228 Victor	
3. NAME OF DECEASED (Type or print) First Infant Middle Last Lewis #1		4. DATE OF DEATH Month August Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1957
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? U.S.A.
13a. FATHER'S NAME Robert Lewis		13b. MOTHER'S MAIDEN NAME Mary Vann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Mary Lewis, mother	
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		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congenital atelectasis.		7620	
DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 8-6-57 to 8-8-57 and last saw her alive on 8-8-57 Death occurred at 5:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.R. Peterson MD (Degree or title)		22b. ADDRESS 600 E. 22nd Street	
		22c. DATE SIGNED 8-21-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-28-57	
23c. NAME OF CEMETERY OR CREMATORY Leid A		23d. LOCATION (City, town, or county) (State) Kansas City MO	
24. FUNERAL DIRECTOR W.R. Peterson		25. DATE RECD. BY LOCAL REG. 8-26-57	
ADDRESS KC MO		26. REGISTRAR'S SIGNATURE Neva Minchall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.



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 Mr. Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Wm A. Schuyler

Licensed Embalmer No. 3089
P. O. Address 140 M

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.