

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32035
STATE FILE NUMBER
3913

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

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> 38
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital No. 1 Life</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>464 Tracy</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Eugene</u> Last <u>Martinez</u>			4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>7-30-57</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INEANT</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>Antonio Martinez</u>		13b. MOTHER'S MAIDEN NAME <u>Ruby West</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 <u>Mrs Ruby Martinez</u> Address <u>464 TRACY</u>
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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) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19</u> <u>26</u> days <u>9630</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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 <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>KANSAS CITY MO</u>	COUNTY _____ STATE _____
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21. I attended the deceased from 7-30-57 to 8-19-57 and last saw her alive on 8-19-57
Death occurred at 4:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. S. Burns, M.D.</u> (Degree or title)	22b. ADDRESS <u>General Hospital No: 1</u>	22c. DATE SIGNED <u>8-20-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-21-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City MO</u>
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24. FUNERAL DIRECTOR <u>Sheil Funeral Home K.P.M.O</u>	ADDRESS <u>K.P.M.O</u>	25. DATE RECD. BY LOCAL REG. <u>8-20-57</u>	26. REGISTRAR'S SIGNATURE <u>neva Minshall</u>
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(Licensed Embelmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.
MEDICAL CERTIFICATION
B. I. Burns



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 *Thomas A. [Signature]*

Licensed Embalmer No. *4954*
P. O. Address *[Signature]*

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.