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FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 36208

11318 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4502

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center — Length of stay in 1b Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3318 Gillham Plaza — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Baby Girl Middle: Last: Waits

4. DATE OF DEATH Month Day Year: September 13, 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9-13-57
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 2 Min. 20

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 Mo.
12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME: Silas Lee Waits
13b. MOTHER'S MAIDEN NAME: Betty Faye Downey
14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Betty Waits Address: 3318 Gillham Plaza

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital malformation head (Cyclops) — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Polyhydramnios
DUE TO (c) — 750+
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 [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 9-13-57 to 9-13-57 and last saw her/him alive on 9-13-57
Death occurred at ~~[illegible]~~ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. P. Farney (Degree or title) MD
22b. ADDRESS: K. C. Mo
22c. DATE SIGNED: 9-25-57

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 9-13-57
23c. NAME OF CEMETERY OR CREMATORY: Gave to Hosp.
23d. LOCATION (City, town, or county) (State): K. C. Mo

24. FUNERAL DIRECTOR: Menorah Hospital ADDRESS
25. DATE RECD. BY LOCAL REG.: 9-17-57
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

J. P. Farney

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. .....

P. O. Address .....

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.