

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44447  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5753

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Children's Mercy Hospital</u> <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Greenridge</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give last name) HOSPITAL OR INSTITUTION <u>Children's Mercy Hospital</u> Length of stay in lb <u>67 days</u>		d. STREET ADDRESS (If outside, give location) <u>R.R. #2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ronnie</u> Middle <u>Dean</u> Last <u>Krusse</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>57</u>
5. SEX <u>Male</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>8/7/57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>3</u> MONTHS <u>38</u> DAYS <u>28</u> HOURS <u>1</u> MIN. IF UNDER 24 HRS.
11. BIRTHPLACE (City and state or country) <u>Windsor, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Conrad Kruse</u>		13b. MOTHER'S MARDEN NAME <u>Dorothy Qidenour</u>	
14. NAME OF HUSBAND OR WIFE <u>infant</u>		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>Conrad Kruse</u> Address <u>Greenridge, Mo. RR #2</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>Malnutrition</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>colitis</u> DUE TO (c) <u>Heischapung's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7562</u>			
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 Month, Day, Year 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		COUNTY	STATE
21. I attended the deceased from <u>9-27-57</u> to <u>12/5/57</u> and last saw <u>him</u> alive on <u>12/5/57</u> Death occurred at <u>2:45</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wayne Hart M.D.</u>		22b. ADDRESS <u>1710 Independence</u> <u>Kansas City, Mo.</u>	
22c. DATE SIGNED <u>12-5-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>12.5.57</u>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) <u>Windsor, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Huston Funeral Home</u> ADDRESS <u>Windsor</u>		25. DATE RECD. BY LOCAL REG. <u>12-5-57</u>	
26. REGISTRAR'S SIGNATURE <u>neva minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the medical certification in the separate manner required by 702.140, Missouri R.S., is optional. 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.



**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 .....

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.**