

No symptoms were listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

HEALTH DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7365-58

58-005405

STATE FILE NUMBER

FILED MAR 3 - 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 686

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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u>		Length of stay in lb <u>2 da.</u>	d. STREET ADDRESS <u>7315 Ditzler Raytown</u>		(If outside, give location) <u>1000</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Infant Kevin Edward</u> Middle <u>Carey</u> Last <u>Carey</u>			4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>58</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>2-6-58</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</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 <u>Infant</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City Missouri</u>	
13. FATHER'S NAME <u>Bernard E. Carey</u>			14. MOTHER'S MAIDEN NAME <u>Mary Lou Milum</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Bernard E. Carey</u> Address <u>7315 Ditzler</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>asphyxia</u> DUE TO (b) <u>Extreme Cyanosis</u> DUE TO (c) <u>cause unknown</u> Congenital heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>7545</u>					INTERVAL BETWEEN ONSET AND DEATH
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> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <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>7545</u>	
21. I attended the deceased from <u>Feb 7, 58</u> to <u>Feb 8, 58</u> and last saw her/him alive on <u>Feb 8, 58</u> Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John Aull M.D.</u> (Degree or title) <u>D</u>			22b. ADDRESS <u>1306 Professional Bldg</u>		22c. DATE SIGNED <u>2-10-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2-10-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
24. BURIAL DIRECTOR <u>Mellody-MCGilley-Eylar</u> ADDRESS <u>20 W. Lin.</u>			25. DATE RECD. BY LOCAL REG. <u>2-10-58</u>		26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John Aull

Dr. John A. ...
Prof. R. L. ...
Dr. ...

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. *50*

P. O. Address *Judg.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.