

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010076
STATE FILE NUMBER
1501

FILED APR 9 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1501

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1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Odessa
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Baby Mason			4. DATE OF DEATH Month Day Year March 22 1958	
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5. SEX Male	6. COLOR OR RACE White	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1958	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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., USA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Albert Mason	13b. MOTHER'S MAIDEN NAME Dora Barker	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Dora Barker	Address Odessa, Mo.
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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) Hydrocephalus DUE TO (b) Cranioclasia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 752*
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 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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	COUNTY	STATE
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21. I attended the deceased from 3-22-58 to 3-22-58 and last saw him alive on 3-22-58 Death occurred at 1:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jacob P. Farney MD	22b. ADDRESS K. C. Mo	22c. DATE SIGNED 3-22-58
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR Ralph O Jones	ADDRESS Odessa, Mo.	25. DATE RECD. BY LOCAL REG. 3.22.58	26. REGISTRAR'S SIGNATURE Neva Minshall
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(Licensed Embalmer's Statement on Reverse Side)

JACOB P. FARNEY USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification
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 *Ralph O. Jones*

Licensed Embalmer No. *4604*

P. O. Address *Odessa*

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.