

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16331-58  
58-010160  
State File No.

FILED MAR 19 1958

1197

BIRTH NO. <u>0</u>		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1197</u>	
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, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 hr. 18 min</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran</u>				d. STREET ADDRESS (If rural, give location) <u>4216 Highland</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jeanne</u>		b. (Middle) <u>Ross</u>		c. (Last) <u>Ross</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 27 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>2-26-58</u>		9. AGE (In years last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>18</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		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Robert Nelson Ross</u>			13b. MOTHER'S MAIDEN NAME <u>Carolyn Jeanne Smythe</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Robert Ross</u>		ADDRESS <u>4216 Highland, K. C. Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity (5 1/2 mo. fetus)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Underdevelopment.</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH  <u>776x</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>2-26-58</u> , 19 <u>58</u> , to <u>2-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> A. M., from the causes and on the date stated above.							
23a. SIGNATURE <u>P. E. Pearson M.D.</u> (Degree or title)				23b. ADDRESS <u>1025 Galt Bldg K.C. Mo</u>		23c. DATE SIGNED <u>3/3/58</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Retained</u>		24b. DATE <u>3 Mar 58</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hospital</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-5-58</u>		REGISTRAR'S SIGNATURE <u>Nevar Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Trinity Lutheran Hosp.</u> ADDRESS <u>K.C. Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
P. E. Pearson



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**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 .....  
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 this body is not embalmed, fact should be so stated above.