

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033011
STATE FILE NUMBER
4016

65010-58
FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1005 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Conley Maternity Hospital Life		Length of stay in 1b. Life	d. STREET ADDRESS (If outside, give location) 1829 Elmwood Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JERRY Middle BEAUTINE Last STEELY			4. DATE OF DEATH Month July Day 3 Year 1958		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1958	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 2 Days 3 IF UNDER 24 HRS. Hours 2 Min. 3	
--------------------	-------------------------------	---	---	--	--

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 Lawrence Dale Steely		13b. MOTHER'S MAIDEN NAME Louise Mattie Wann		14. NAME OF HUSBAND OR WIFE none	
---	--	--	--	--	--

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 X Louise Steely	Address 1829 Elmwood
--	--	---	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 3 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ateleotasis			
DUE TO (c) Prematurity			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 4:30 Month, Day, Year PM July 3, 1958	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION K. C. College of Osteopathy & Surgery, K. C., Mo.	COUNTY K. C.	STATE Mo.
---	--	--	------------------------	---------------------

21. I attended the deceased from July 3, 1958 to July 3, 1958 and last saw her alive on July 3, 1958 Death occurred at 4:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.				
--	--	--	--	--

22a. SIGNATURE (Degree or title) William D. Hand, Jr., D.O.		22b. ADDRESS 605 Woodland, K. C., Mo.		22c. DATE SIGNED 7/23/58
---	--	---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Retained	23b. DATE 7/3/58	23c. NAME OF CEMETERY OR CREMATORY K. C. College of Osteopathy & Surgery, K. C., Mo.	23d. LOCATION (City, town, or county) (State) K. C., Mo.
--	----------------------------	--	--

24. FUNERAL DIRECTOR K. C. College of Osteopathy, K. C., Mo.	ADDRESS K. C., Mo.	25. DATE RECD. BY LOCAL REG. 8-20-58	26. REGISTRAR'S SIGNATURE neva Minshall
--	------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

WILLIAM D. HAND, JR., D.O. MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



Name of Deceased: _____
 Address: _____
 Date of Death: _____
 Cause of Death: _____
 Place of Death: _____
 Name of Embalmer: _____
 License No.: _____

Place of Embalming

Signature of

Embalmer

STATEMENT BY LICENSED EMBALMER

Signature of

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.