

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044024
STATE FILE NUMBER

98922-58
FILED JAN 5 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5932

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 Menorah Medical Center		c. CITY OR TOWN Grandview	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Length of stay in 1b 2 days	
3. NAME OF DECEASED (Type or print) First Maxine Middle Cassity Last Cassity		4. DATE OF DEATH Month 12 Day 15 Year 1958	
5. SEX Female	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 12-13-58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	9. AGE (In years last birthday) 2
11. BIRTHPLACE (City and state or country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Walter Webster Cassity		13b. MOTHER'S MAIDEN NAME Maxine Knolls	
14. NAME OF HUSBAND OR WIFE ----		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 Walter Webster Cassity - 705 Zumwalt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Erythroblastosis fetalis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7760			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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 Birth to 12-15-58 and last saw ^{her} him alive on 12-15-58 Death occurred at _____ p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE William L. Doane MD (Dressed or title)		22b. ADDRESS Grandview, MO	
22c. DATE SIGNED 12-16-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 16, 1958	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Butler, Missouri	
24. FUNERAL DIRECTOR Stine & McC ure Und. Co., K.C., Missouri		25. DATE RECD. BY LOCAL REG. 12-16-58	
26. REGISTRAR'S SIGNATURE Neva Minshall			

(Licensed Embalmer's Statement on Reverse Side)

William L. Doane 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 *Clms D. Triplett*

Licensed Embalmer No. *4817*
P. O. Address *K.C. Mo.*

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.