Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-044229

STATE FILE NUMBER 5607

FILED DEC 18 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) GENERAL HOSPITAL Length of stay in Hospital 2 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3424 TROOST Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First ~~[illegible]~~ JAMES Middle LEROY Last LAWSON
4. DATE OF DEATH Month Nov. Day 23 Year 1958
5. SEX Male
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 11-21-1958
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 2 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10b. KIND OF BUSINESS OR INDUSTRY INFANT
11. BIRTHPLACE (City and state or country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME ROWENA LAWSON
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 ROWENA LAWSON Address 3424 TROOST KC, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature infant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bilateral atelectasis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7525
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 WORK [ ] NOT WHILE AT WORK [ ]
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 11-22-58, to 11-23-58 and last saw her/him alive on 11-23-58
Death occurred at 5:35A. m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Abraham Gelperin M.D. (Degree or title)
22b. ADDRESS General Hospital KC, Mo.
22c. DATE SIGNED 11-24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-16- ~~11-29~~-1958
23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY
23d. LOCATION (City, Town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES ADDRESS K.C., Mo.
25. DATE RECD. BY LOCAL REG. 11-27-58
26. REGISTRAR'S SIGNATURE Neva Marshall
(Licensed Embalmer's Statement on Reverse Side)

Abraham Gelperin M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. 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 B. E. Weilert

Licensed Embalmer No. 4075

P. O. Address K.C. 8, 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.