

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001321

STATE FILE NUMBER

FILED FEB 5 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 173

300
-57

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, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS (If outside city location) <u>4143 Montgall</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Pita</u> Middle <u>Louise</u> Last <u>Lutierrez</u>			4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1959</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Baby</u>	9c. AGE (In years last birthday) <u>5</u>	9d. UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.
10a. FATHER'S NAME <u>Peter Lutierrez</u>		10b. MOTHER'S MAIDEN NAME <u>Aurora Zuniga</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. NAME OF HUSBAND OR WIFE <u>None</u>		14. SOCIAL SECURITY NO. <u>None</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S NAME <u>Peter Lutierrez</u>		Address <u>4143 Montgall, Jackson, Mo.</u>	
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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) <u>Acute Peritonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs -</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Perforation greater curvature of stomach</u>			<u>24 hrs -</u>		
DUE TO (c) <u>Congenital absence of muscle on greater</u>			<u>of stomach curvature</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7</u>					

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.) <u>7</u>		
20c. TIME OF INJURY Hour <u>7</u> Month <u>7</u> Day <u>10</u> Year <u>1958</u> a.m. <u>30</u> p.m.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

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.) <u>U.S.A.</u>	20f. CITY, TOWN, OR LOCATION <u>U.S.A.</u>	COUNTY <u>U.S.A.</u>	STATE <u>U.S.A.</u>
21. I attended the deceased from <u>Jan 6 1958</u> to <u>Jan 10 1958</u> and last saw her alive on <u>Jan 10 1958</u> Death occurred at <u>12:30 pm Jan 10 1958</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ned W. Small</u> (Degree or title) <u>U.S.A.</u>			22b. ADDRESS <u>411 Meadows Gap E.O. 740</u>		22c. DATE SIGNED <u>1-10-59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>1-12-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>Robert Funeral Homes & Crem.</u>		ADDRESS <u>1-11-59</u>	25. DATE RECD. OF MEDICAL REC. <u>1-11-59</u>	26. REGISTRAR'S SIGNATURE <u>Ned W. Small</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Ned W. Small

All diseases in Part I must be causally related.

(Licensed Embroider's Statement on Reverse Side)

11-1-50

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 Westert*
Licensed Embalmer No. *4025*
P. O. Address *208 1/2*

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.