Health, Welfare & Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001416
STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St Luke's Hospital — Length of stay in Hospital: 1 1/2 HRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 6909 E. 55th — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Myron Middle: Carroll Last: McDonald

4. DATE OF DEATH: Month 1 Day 1 Year 59

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7/12/57
9. AGE (In years last birthday): 1 1/2 yrs — IF UNDER 1 YEAR: Months / Days — 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 Mo Jackson
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Gordon McDonald
13b. MOTHER'S MAIDEN NAME: Wanda Franks
14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Father — Address: 6909 E 55th 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): Acute Diffuse Primary Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Dehydration acidosis — 30 hrs
DUE TO (c): Acute Diarrhea — 60 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 [X]
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 7/12/57 to 1/1/59 and last saw him alive on 11/6/58
Death occurred at 10:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Herbert V. Davis MD (Degree or title)
22b. ADDRESS: 4620 Jackson Pkwy
22c. DATE SIGNED: 1/1/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 2, 1959
23c. NAME OF CEMETERY OR CREMATORY: Decatur Cemetery
23d. LOCATION (City, town, or county) (State): Decatur Arkansas

24. FUNERAL DIRECTOR: D.W. Newcomer Sons — ADDRESS: Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 1-1-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Herbert V. Davis

X

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 Marvin L. Preston

Licensed Embalmer No. 5040

P. O. Address Kansas City,

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.