Health, Welfare Public Service

300
1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005690
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 763

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp. — Length of stay in 1b 3 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 ☒ No ☐
d. STREET ADDRESS 1184 E. 65th (If outside, give location) ~~St. Mary's Hosp.~~ — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Infant Middle: Barbara Last: Layman

4. DATE OF DEATH Month: Feb. Day: 6 Year: 1959

5. SEX Female

6. COLOR OR RACE Caus.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 3, 1959

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months: ; Days: 3 — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Kansas City, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Donald Layman

13b. MOTHER'S MAIDEN NAME Sue Simpson

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. None

17. INFORMANT R. D. Simpson Address 1184 E. 65th St.

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) anoxia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hyaline membrane Disease — 3 days
DUE TO (c) Prematurity — 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hyperbilirubinemia cause undetermined

19. WAS AUTOPSY PERFORMED? YES ☒ 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 3 Feb '59, to 6 Feb '59 and last saw her alive on 6 Feb 59
Death occurred at 10:15 pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thomas E. Draney M.D. (Degree or title)

22b. ADDRESS 4526 Paseo

22c. DATE SIGNED 9 Feb '59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Feb. 10, 1959

23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery

23d. LOCATION (City, town, or county) Kansas City (State) Missouri

24. FUNERAL DIRECTOR Muehlebach

ADDRESS 6800 Troost

25. DATE RECD. BY LOCAL REG. 2-10-59

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Thomas E. Draney

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 .....

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.