Health, Welfare Public Service

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1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005756
STATE FILE NUMBER 768

Registration District No. 149 Primary Registration District No. 10.02 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 ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Conley Maternity Clinic — Length of stay in Ib 20 min.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Wyandotte
c. CITY OR TOWN Kansas City 21.50 8 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 13 1/2 S. James — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First MONICA Middle ELIZABETH Last MONTES
4. DATE OF DEATH Month Day Year Feb. 7, 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2 - 7 - 59
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS. Hours 0 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
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 Charles Montes
13b. MOTHER'S MAIDEN NAME Mary Ann Ramos
14. NAME OF HUSBAND OR WIFE - -

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 Charles Montes, Address K.C.K.

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) Respiratory Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Premature Birth
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)
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 2-7-59 to 2-7-59 and last saw her him alive on 2-3-59.
Death occurred at 2:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles S. Fazio (Degree or title) D.O
22b. ADDRESS 243 1/A Independence
22c. DATE SIGNED 2-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-7-1959
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary
23d. LOCATION (City, town, or county) (State) Kansas City, Kansas

24. FUNERAL DIRECTOR Skradski - Stine F. H. ADDRESS K.C.K.
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.

Charles S. Fazio

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 Matt Shradski

Licensed Embalmer No. 4382

P. O. Address K C K

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.