Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005810
STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 666

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION General #2 — Length of stay in Hospital Life

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 2109 Brooklyn (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Infant Powell

4. DATE OF DEATH Month Day Year: January 21, 1959

5. SEX Male

6. COLOR OR RACE Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH 1-18-59

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): Infant

10b. KIND OF BUSINESS OR INDUSTRY

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

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME none

13b. MOTHER'S MAIDEN NAME Tommie Powell

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 Tommie Powell — Address 2109 Brooklyn

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) Absence of ventricular septum. (Cor triloculare biatrium)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
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 1-18-59, to 1-21-59 and last saw her/him alive on 1-21-59
Death occurred at 8:20 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) — **22b. ADDRESS** 600 East 22nd Street — **22c. DATE SIGNED** 1-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **23b. DATE** 2-6-59 — **23c. NAME OF CEMETERY OR CREMATORY** Lucas — **23d. LOCATION** (City, town, or county) (State) Kansas City Mo

24. FUNERAL DIRECTOR — **ADDRESS** — **25. DATE RECD. BY LOCAL REG.** 2-4-59 — **26. REGISTRAR'S SIGNATURE** Neva Minshall

(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.

E. Frank Ellis

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 Not Embalmed, Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Wm A Schmuyer

Licensed Embalmer No. 3089

P. O. Address K C 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.