Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008753

STATE FILE NUMBER

LED MAR 19 1959 Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY Clay	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Clay
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) North Kansas City — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Kansas City 5009 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Memorial Hospital — Length of stay in 1b 6 Hrs.	d. STREET ADDRESS (If outside, give location) 2412 E. 52nd St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Renee	Middle Lynn	Last McFarland	4. DATE OF DEATH Month March Day 8 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH April 2, 1957
9. AGE (In years last birthday) 1	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) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Jack J. Mc Farland	13b. MOTHER'S MAIDEN NAME Mary Jane Thomas	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 Jack J. Mc Farland Address 2412 E. 52nd St. K. C. 16	

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) Toxemia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) acute Tracheobronchitis

DUE TO (c) Organism as yet unidentified

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)

Hepatic Insufficiency due to cirrhosis of Liver

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.) 500X

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 3-7-59, to 3-8-59 and last saw her/him alive on 3-8-59

-Death occurred at 12:30 Am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James E McCormick, MD	22b. ADDRESS 4030 N Oak 11 C 16 Mo	22c. DATE SIGNED 3-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-10-59	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery
23d. LOCATION (City, town, or county) (State) Clay County, Mo.		
24. FUNERAL DIRECTOR ADDRESS D. W. Newcomer's Sons N. K. C Mo.	25. DATE RECD. BY LOCAL REG. 3-9-59	26. REGISTRAR'S SIGNATURE Marguerite Hudgens

(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.

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CLAY
HEALTH

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 Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 16, M

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.