

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009455

STATE FILE NUMBER

ED MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1178

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Holden
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.		Length of stay in lb 2 hrs.	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Infant Hirni			4. DATE OF DEATH Month Day Year 3. 2. 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3. 2. 59		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City, Missouri.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.						

13a. FATHER'S NAME Troy Edward Hirni.	13b. MOTHER'S MAIDEN NAME Norma Mae Mallies	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Troy E Hirni, Holden, Mo	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 3 1/2 months		INTERVAL BETWEEN ONSET AND DEATH Two hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 9:45 AM 3/2/59 to 11:45 AM 3/2/59 and last saw her alive on 3/2/59 Death occurred at 11:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE Sam D. Hoepfer, M.D., Grandview, Mo.	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED mar 3. 1959
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23a. BURIAL CREMATION, REMOVAL (Mark)	23b. DATE 3. 2. 59	23c. NAME OF CEMETERY OR CREMATORY St. Joseph Hosp.	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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24. FUNERAL DIRECTOR Disposed of by St. Joseph Hospital Laboratory	ADDRESS	25. DATE RECD. BY LOCAL REG. 3-4-59	26. REGISTRAR'S SIGNATURE neva minshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Sam D. Hoepfer



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.