

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009643

STATE FILE NUMBER  
1235

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1235

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 JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location) TRINITY LUTHERAN HOSP		Length of stay in 1b 12 HRS	d. STREET ADDRESS (If outside, give location) 7427 WALNUT
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First: JOHN Middle: PETER Last: SCHLAMB.			4. DATE OF DEATH Month: Mar. Day: 3 Year: 1959		
---	--	--	---	--	--

5. SEX MALE	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 MAR. 3-1959	9. AGE (In years last birthday) 12	IF UNDER 1 YEAR Months: Days: Hours: Min.	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, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME KERMIT SCHLAMB	13b. MOTHER'S MAIDEN NAME CAROL PRETORIUS	14. NAME OF HUSBAND OR WIFE NONE
--------------------------------------	--	-------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT KERMIT SCHLAMB	Address: 7427 WALNUT STREET KANSAS CITY, MISSOURI
---	---------------------------------	---------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hyaline Membrane		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
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) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>on 3-3-59</u> to <u>3-3-59</u> and last saw her alive on <u>3-3-59</u> Death occurred at <u>10:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) Ernest S. Glasscock, M.D.	22b. ADDRESS Plaza Time Bldg.	22c. DATE SIGNED 3-6-59
---	----------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE MARCH 6, 1959	23c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS	23d. LOCATION (City, town, County) (State) KANSAS CITY MISSOURI
--	----------------------------	---	--

24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS-KANSAS CITY	25. DATE RECD. BY LOCAL REG. 3-7-59	26. REGISTRAR'S SIGNATURE Irene Minshall
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
Ernest L. Glasscock USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Kern Lawler* .....

..... Licensed Embalmer No. *4915*  
P. O. Address *KC 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.