Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013635
STATE FILE NUMBER 1728

FILED APR 20 1959

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City, Mo — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION Children's Mercy — Length of stay in 1b DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN ~~Columbia~~ CREOR Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 4228 Virginia (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Joy Middle LaUerne Last Young
4. DATE OF DEATH Month 4 Day 4 Year 59
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-19-58
9. AGE (In years last birthday) 1 YR — IF UNDER 1 YEAR Months ~~16~~ 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 Child
11. BIRTHPLACE (City and state or country) K.C. Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Young
13b. MOTHER'S MAIDEN NAME Lucille Henderson
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 Lucille Young Address 4228 Virginia KCMo

MEDICAL CERTIFICATION — USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration & hyperthermia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) nausea & vomiting
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 ☒ 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 4:20 a.m. p.m. Month, Day, Year 4-4-59
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 4-4-59, to 4-4-59 and last saw her/him alive on 4-4-59
Death occurred at 4:20 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. D. Parman M.D. (Degree or title)
22b. ADDRESS 1700 Indep. Ave
22c. DATE SIGNED 4-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4-5-59
23c. NAME OF CEMETERY OR CREMATORY —
23d. LOCATION (City, town, or county) (State) Vienna Missouri

24. FUNERAL DIRECTOR Birmingham Mort. ADDRESS Vienna Mo
25. DATE RECD. BY LOCAL REG. 4-4-59
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

R. D. Parman

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 John R. Sidmo

Licensed Embalmer No. 4531

P. O. Address Kansas

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.