

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017831
STATE FILE NUMBER

FILED MAY 29 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2218

300
1-57 D

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) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Children's Mercy		d. STREET ADDRESS 4911 E. 27th	
Length of stay in lb # days		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy McCallen			4. DATE OF DEATH Month Day Year 5-3-'59	
---	--	--	---	--

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 4-28-59	9. AGE (In years last birthday) 4 days	IF UNDER 1 YEAR Months Days Hours Min. 4 25	IF UNDER 24 HRS.
-------------	------------------------	--	--------------------------	---	---	------------------

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) K.C. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
--	-----------------------------------	---	-----------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Jean McCallen	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 MRS. B. Schrogo - 4911 E. 27th	Address
--	------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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) 7635		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 4-28-59 to 5-3-59 and last saw her/him alive on 5-3-59	
Death occurred at 9:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE R.P. Parman M.D. (Degree or title)	22b. ADDRESS 1700 Indep Ave.	22c. DATE SIGNED 5-3-59
---	------------------------------	-------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-4-59	23c. NAME OF CEMETERY OR CREMATORY Green Lawn	23d. LOCATION (City, town, or county) (State) Kansas City MO
--	------------------	---	--

24. FUNERAL DIRECTOR France-Wornall Funeral Home	ADDRESS	25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE Neva Marshall
--	---------	-------------------------------------	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

R. D. Pauman



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 *Russell N. France*

Licensed Embalmer No. *4256*

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.