

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021287

STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. _____

149

Primary Registration District No. _____

1002

Registrar's No. _____

2641

300

1-57

All diseases in Part I must be causally related.

Camron F. Marshall
MEDICAL CERTIFICATION
MARSHALL BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Platte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN LAKE WAUKOMISS.	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes. Hosp.		d. STREET ADDRESS PARKWIDE DR. No. LAKE SHORE DR. No.	
3. NAME OF DECEASED (Type or print) JAMES JOHN GRADY J. CRICHTON		4. DATE OF DEATH Month Day Year May 19 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 5-18-59
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) Kansas City Missouri
13a. FATHER'S NAME John G. Crichton		13b. MOTHER'S MAIDEN NAME Elaine G. Brown	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	17. INFORMANT John G. Crichton Address 325 Mo Lake Shore Dr
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unexpanded lungs DUE TO (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 24 hrs 15 min 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 Death occurred at MAY 18-59 to MAY 19, 59 and last saw her alive on MAY 19, 59		22a. SIGNATURE Camron F. Marshall M.D.	
22b. ADDRESS K.C. Mo.		22c. DATE SIGNED 5-28-59	
23a. BURIAL (REMOVAL) CREMATION	23b. DATE May 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Cremation D.W. Newcomers Soc	23d. LOCATION (City, town, or county) (State) K.C. Mo.
24. FUNERAL DIRECTOR D.W. Newcomers Soc		25. DATE RECD. BY LOCAL REG. 5-28-59	26. REGISTRAR'S SIGNATURE newminshall

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 *Basil J. Honey,*

Licensed Embalmer No. *47241*
P. O. Address *R.C., Ma.*

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.