

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021765

STATE FILE NUMBER

FILED JUL 8 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3051

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 OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS 5916 WABASH	

3. NAME OF DECEASED First Middle Last PATRICK LEE WEST			4. DATE OF DEATH Month Day Year JUNE 21 1959			
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1959	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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 MO.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME FRED WEST		13b. MOTHER'S MAIDEN NAME PATRICIA KAY ADAMSON		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FRED WEST, 5916 WABASH K.C. MO	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH 8 hrs
DUE TO (b) Exaline Membrane		
DUE TO (c) Prematurity & lungs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7735		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 June 20 1959 to June 21 1959 and last saw her alive on June 21 1959 Death occurred at 6:45 am on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Neva Munchall			22b. ADDRESS 411 NICHOLS ROAD		22c. DATE SIGNED 6-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE June 24 1959	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.
24. FUNERAL DIRECTOR MUEHLEBACH		ADDRESS 6800 TROOST		25. DATE RECD. BY LOCAL REG. 6-22-59	26. REGISTRAR'S SIGNATURE Neva Munchall

All diseases in Part I must be causally related.
 Ned W. Small M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

411 Nichols
Dr. Small

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 *B. E. Nichols*

Licensed Embalmer No. *4997*

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.