

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024504

FILED VS AUG 5 1959

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NO KANSAS CITY</u>	Length of stay in 1b <u>1hr. 20min</u>	c. CITY OR TOWN <u>GLADSTONE</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NO. K.P. MEMORIAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>105 W 68th</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>STERLING</u> Last <u>MAP</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1959</u>			
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5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours
						Min. <u>20</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>NO. K.C. MO.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>PAUL S. MAP</u>	13b. MOTHER'S MAIDEN NAME <u>GLADYS R. EIDSON</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>NO K.P. MEMORIAL HOSPITAL</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Emphysema of left lung</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. Month, Day, Year	
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 7-29-59 to 7-29-59 and last saw her alive on 7-29-59
Death occurred at 7:29-59 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Melvin Langford M.D.</u> (Degree or title)	22b. ADDRESS <u>1616 Monroe St 16 Mo</u>	22c. DATE SIGNED <u>7-29-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-7-59 Burial</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>East Slope</u>	23d. LOCATION (City, town, or county) (State) <u>Meruende, Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer Sons</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Marquette Judgens</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

Melvin Langford M.D. CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John W. Kalsbeck

Licensed Embalmer No. 4949

P.O. Address No. Lanson

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to 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.