

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 14 1959 49

59-025097

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3733

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Kansas City</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>Menorah Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6024 N. Wayne</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Eldridge</u> Last <u>Eldridge</u>			4. DATE OF DEATH Month <u>July</u> Day <u>31st</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>July 31, 1959</u>	9. AGE (last birthday) <u>8 hrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours <u>8</u> Min. <u>5</u>
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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 <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo. U.S.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13. FATHER'S NAME <u>John Eldridge</u>	13b. MOTHER'S MAIDEN NAME <u>Mellican Farr</u>	14. NAME OF HUSBAND OR WIFE <u>John Eldridge</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (know) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>John Eldridge</u> Address <u>6024 N. Wayne</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: IMMEDIATE CAUSE (a) <u>atelectasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prematurity</u> DUE TO (c) _____		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 (e)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 7-31-59 to 7-31-59 and last saw her/him alive on 7-31-59
Death occurred at 10:30 am 7/31/59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>L. Ketterman M.D.</u> (Degree or title)	22b. ADDRESS <u>Hickman Mills</u>	22c. DATE SIGNED <u>8-1-59</u>
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22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 4/59</u>	23. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Garden</u>	23d. LOCATION (City, town, or county) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Colandrea</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>	26. REGISTRAR'S SIGNATURE <u>new minshel</u>
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DOCUMENT

BY AFFIDAVIT OF L. Ketterman - MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.