

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025375

STATE FILE NUMBER

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3044

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Palmer Lake Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cerebral Palsy Center		Length of stay in lb 6 Wks	d. STREET ADDRESS (If outside, give location) Box 341, Rt. 1 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jonathan Middle Jaymes Last Redmon			4. DATE OF DEATH Month June Day 22 Year 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 May 16, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Colorado
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Robert Redmon	
13b. MOTHER'S MAIDEN NAME Mildred (Unknown)		14. NAME OF HUSBAND OR WIFE Not Married	
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 Address Cerebral Palsy Center Records, Kansas City, 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) celiac disease and cerebral palsy DUE TO (b) R. H. negative DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2860	
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 7:55 a. Month, Day, Year 6-22-59 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 5-22-59 to 6-22-59 and last saw her alive on 6-22-59 . Death occurred at 7:55 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Gene E. Hughes, M.D.		22b. ADDRESS 6509 Prospect KCMo	
22c. DATE SIGNED 7/1/59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 6-22-59		23c. NAME OF CEMETERY OR CREMATORY Evergreen	
23d. LOCATION (City, town, or county) (State) Colorado Springs, Colorado		24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.	
25. DATE RECD. BY LOCAL REG. 6-22-59		26. REGISTRAR'S SIGNATURE neva minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William M. Jurr*

Licensed Embalmer No. *464*
P. O. Address *Kansas City*

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.