

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959 147

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

4092

59-028972

STATE FILE NUMBER

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>KANSAS</b> b. COUNTY <b>JOHNSON</b> |  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS City, Mo.</b>   |   | Length of stay in lb<br><b>20 days</b>  |  | c. CITY OR TOWN <b>MERRIAM</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>7201 W. 60</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ANN</b> Middle <b>ELIZABETH</b> Last <b>BIXENMAN</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>22</b> Year <b>1959</b>   |  |  |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-2-59</b>  | 9. AGE (last birthday)<br><b>20 days</b>   |  | IF UNDER 1 YEAR<br>Months _____ Days <b>20</b>                             | IF UNDER 24 HR<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHILD</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  | 11. BIRTHPLACE (City and state or country)<br><b>KANSAS City Mo</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |  |
| 13a. FATHER'S NAME<br><b>GERALD L. BIXENMAN</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>GERALDINE SAMPSON</b>                                |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>—</b>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><input checked="" type="checkbox"/>  |   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>GERALD BIXENMAN</b> Address <b>MISSION K</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>jejunal atresia</b>   |   |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 days</b>                         |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |   |   | DUE TO (b) _____   |  | DUE TO (c) _____   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>prematurity</b>  |   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  |   |   |  |  |  |  |  |  |
| 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  |  |
| 21. I attended the deceased from <b>8-6-59</b> to <b>8-22-59</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>8-22-59</b><br>Death occurred at <b>5:30 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Chas. Thomas Jr. MD</b>   |   |   |  | 22b. ADDRESS<br><b>4706 Broadway K.C. Mo</b>   |  | 22c. DATE SIGNED<br><b>8-23-59</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  | 23b. DATE<br><b>AUG 24 59</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESURRECTION</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>LENEXA KS.</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>JOS A BUTLER'S SONS KSK</b> ADDRESS _____   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>8-24-59</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Leva Minchall</b>                                    |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF THOMAS JR.

**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 Russell W Dennis

Licensed Embalmer No. 346

P. O. Address K C K

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.