

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029077**

**FILED VS SEP 4 1959**

**4061**

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>2 DAYS</b>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CONLEY Maternity Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6505 No. MCGEE</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>EDWARD</b> Last <b>FITSCHEN</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 17, 1959</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>ROBERT S. FITSCHEN</b>		13b. MOTHER'S MAIDEN NAME <b>DONNA MARSH</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>ROBERT S. FITSCHEN - 6505 N. MCGEE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1</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)				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 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 _____ a.m. _____ p.m.		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.) <b>Birth</b>		20f. CITY, TOWN, OR LOCATION <b>315</b>	
21. I attended the deceased from _____ to <b>8-19-59</b> and last saw her alive on <b>8-19-59</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>D. Reese</b> (Degree or title)			22b. ADDRESS <b>3309 E 12</b>		22c. DATE SIGNED <b>8-21-59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUGUST 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN</b>		23d. LOCATION (City, town, or county) <b>K.C., Mo.</b>
24. FUNERAL DIRECTOR <b>C.H. Blackmon &amp; Son Inc.</b>		25. DATE RECD. BY LOCAL REG. <b>8-21-59</b>		26. REGISTRAR'S SIGNATURE <b>Drew Minshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address H. C. M.

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.