

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029350

FILED VS SEP 4 1959 149

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

4074

STATE FILE NUMBER

360

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KAUSAS CITY</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKES</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KAUSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2910 TROOST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MIRIAM</u> Middle <u>ELAINE</u> Last <u>VAIL</u>			<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>20</u> Year <u>59</u>				
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-24-57</u>	<b>9. AGE (last birthday)</b> <u>1</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>K.C. MO</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u>	
<b>13a. FATHER'S NAME</b> <u>CRANDALL VAIL</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>RUTH BEEDE</u>			<b>14. NAME OF HUSBAND OR WIFE</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>CRANDALL VAIL</u> Address <u>2910 TROOST AVE</u> <u>KAUSAS CITY MO</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphatic Leukemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypostatic pneumonia</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 type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>  <u>2 days</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>Aug 11, 1959</u> <b>to</b> <u>Aug 20, 1959</u> <b>and last saw her</b> <u>alive on Aug 20 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Charles J. Eldridge M.D.</u>				<b>22b. ADDRESS</b> <u>409 E 63rd St - K.C. 10 Mo</u>		<b>22c. DATE SIGNED</b> <u>8-21-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>AUG 22 59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREENLAWN CEM</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>KAUSAS CITY MISSOURI</u>		
<b>24. FUNERAL DIRECTOR</b> <u>D.W. NEWCOMER'S SON</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-21-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Minichall</u>	

DOCUMENT

BY AFFIDAVIT OF Charles J. Eldridge M.D. 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 Chester K. Broe

Licensed Embalmer No. 493

P. O. Address KCM

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.