

Health, Welfare, Public Service

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

R. D. Parman

MEDICAL CERTIFICATION

FILED VS OCT 7 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-032271

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4507

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> 3418 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Childrens Mercy Hospital</i>		Length of stay in <i>19 1/2</i> days	d. STREET ADDRESS (If outside, give location) <i>2404 Tracy</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Rose Monda Combs</i>			4. DATE OF DEATH Month Day Year <i>9 14 1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	07. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-3-1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days Hours Min. <i>4 11</i>
11. BIRTHPLACE (City and state or country) <i>Kansas City, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Neal Combs</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Ruth Timley</i>	
14. NAME OF HUSBAND OR WIFE <i>none</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Neal Combs</i> Address <i>2404 Tracy</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Gastroenteritis</i>			INTERVAL BETWEEN ONSET AND DEATH
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) <i>5710</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
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 <i>9-13-59</i> to <i>9-14-59</i> and last saw her/him alive on <i>9-14-59</i> Death occurred at <i>6:42 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R.D. Parman M.D.</i> (Degree or title)		22b. ADDRESS <i>Childrens Mercy Hospital</i>	22c. DATE SIGNED <i>9-14-59</i>
23a. BURIAL, CREMATION, etc. (Specify) <i>burial</i>	23b. DATE <i>9-19-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Blue Ridge Lawn</i>	23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo.</i>
24. FUNERAL DIRECTOR <i>Watkins Bros. Fu. Home 18th Benton</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>9-16-59</i>	26. REGISTRAR'S SIGNATURE <i>neve menhall</i>

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 *Bruce A. Watkins*

Licensed Embalmer No. *4500*
P. O. Address *1000 Benton*

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.