

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032364

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4673 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Excelsior Springs	
c. FULL NAME OF (If NOT in hospital, give location) Childrens Mercy Hospital		d. STREET ADDRESS RR #1	

3. NAME OF DECEASED (Type or print) First Debrah Middle Lynn Last Hale	4. DATE OF DEATH Month 9 Day 23 Year 59
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5. SEX Female	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 8-12-59	9. AGE (last birthday) IF UNDER 1 YEAR: Months 1 Days 11 Hours 23 IF UNDER 24 HR: Hours 23 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Excelsior Springs Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Archie Hale	13b. MOTHER'S MAIDEN NAME Heleahouse Elliott	14. NAME OF HUSBAND OR WIFE Infant
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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 Archie Hale	Address Excelsior Springs Mo RR #1
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia		INTERVAL BETWEEN ONSET AND DEATH unk
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) Pierre-Robins syndrome		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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour 12:35 a.m. p.m.	Month, Day, Year
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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 Excelsior Springs	COUNTY Clay	STATE Missouri
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21. I attended the deceased from **8-12-59** to **9-23-59** and last saw her ^{him} alive on **9-23-59**
Death occurred at **12:35** **A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H C Miller M.D.	(Degree or title)	22b. ADDRESS 1710 Independence Ave.	22c. DATE SIGNED 9/23/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-23-59	23c. NAME OF CEMETERY OR CREMATORY CROWN HILL	23d. LOCATION (City, town, or county) (State) Excelsior Springs, Mo.
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24. FUNERAL HOME, PLACE OF BURIAL, CREMATION, OR REMOVAL Priestard Funeral Home, Inc. Excelsior Springs, Missouri	25. DATE RECD. BY LOCAL REG. 9-26-59	26. REGISTRAR'S SIGNATURE Irva Minshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **H. C. Miller**

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 Lindell J. Armon

Licensed Embalmer No. 4589
P. O. Address Franklin Springs

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.