RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 7 1959

59–032446

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4581

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Menorah Medical Center
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3306 Woodland
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: Lewis

4. DATE OF DEATH: Month 9 Day 15 Year 59

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-15-59
9. AGE (last birthday): 9-15-59
IF UNDER 1 YEAR: Months / Days: 15 min
IF UNDER 24 HR: Hours / Min.: ~~12.10 pm~~

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Kansas City, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: James Arthur Lewis
13b. MOTHER'S MAIDEN NAME: Charlesetta Coffey
14. NAME OF HUSBAND OR WIFE: None

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: Charlesetta Lewis Address: 3306 Woodland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) atelectasis, bilateral
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO (b)~~ severe bilateral hydronephrosis hydroureter
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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? ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☒
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION ~~Kansas City~~ COUNTY ~~Jackson~~ STATE ~~Missouri~~

21. I attended the deceased from 9-15-59, to 9-15-59 and last saw her/him alive on 9-15-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Marion W. Richardson MD
22b. ADDRESS: 3526 Prospect
22c. DATE SIGNED: 9/8/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Retained
23b. DATE: 9-15-59.
23c. NAME OF CEMETERY OR CREMATORY: Baby signed to the Department of Pathology of Menorah Hosp.
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR: Menorah Hosp. K.C. Mo.
ADDRESS
25. DATE RECD. BY LOCAL REG.: 9-21-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Marion W. Richardson MEDICAL CERTIFICATION

DOCUMENT

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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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