

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039990

FILED VS DEC 7 1959 149

STATE FILE NUMBER

Registration District No. 1002 Registrar's No. 5594

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Joseph Hospital		Length of stay in 1b OR 4 hrs 3 min		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 5835 Quincey		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5835 Quincey		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year				
Infant Cox			11 18 59				
5. SEX Boy	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 11-18-59	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City Missouri	12. CITIZEN OF WHAT COUNTRY United States		
13a. FATHER'S NAME Bill Oliver Cox		13b. MOTHER'S MAIDEN NAME Betty Jane Helton		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 Address Bill O. Cox 5835 Quincey K.C. Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Prematurity Immaturity							4 hrs 3 min
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 type="checkbox"/> NO <input checked="" 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 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.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE		
21. I attended the deceased from Nov 18-59 to Nov 18-59 and last saw him alive on Nov 18-59							
Death occurred at 6:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Sam D. Hooper, M.D.				22b. ADDRESS Brandview, Mo.		22c. DATE SIGNED Nov 19-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Hospital Disposition		23b. DATE 11-18-59	23c. NAME OF CEMETERY OR CREMATORY St. Joseph Hosp		23d. LOCATION (City, town, or county) Kansas City, Mo.		(State)
24. FUNERAL DIRECTOR		ADDRESS St. Joseph Hosp. K-C. Mo.		25. DATE RECD. BY LOCAL REG. 11-20-59	26. REGISTRAR'S SIGNATURE Mervin Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Sam D. Hooper

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.