URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–039996

STATE FILE NUMBER

FILED VS DEC 7 1959

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5577

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Life ~~12 days~~ Length of stay in 1b
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) 5017 Brooklyn Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Phillip Middle David Last Crosby
4. DATE OF DEATH Month 11 Day 18 Year 59
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10/26/1959
9. AGE (last birthday) IF UNDER 1 YEAR Months ~~1~~ Days 23 IF UNDER 24 HR Hours Min.
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) Kansas City Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Lloyd Crosby
13b. MOTHER'S MAIDEN NAME Mary Ann Hickerson
14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. lloyd Crosby Address Kansas City Missouri 5017 Brooklyn Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Central Nervous System Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH 2 hours
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) Intermittent vomiting since birth
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 Nov. 8-59, to Nov. 18-59 and last saw her/him alive on Nov. 18-59
Death occurred at 5:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jane Zabel Waxman (Degree or title) M.D.
22b. ADDRESS 4840 Prospect
22c. DATE SIGNED Nov. 18 '59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11/19/1959
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City Missouri

24. FUNERAL DIRECTOR D.W. Newcomers Sons ADDRESS 1331 Brush Creek Blvd. Kansas City Missouri (Licensed Embalmer's Statement on Reverse Side)
25. DATE RECD. BY LOCAL REG. 11-19-59
26. REGISTRAR'S SIGNATURE Neva Minshall

DOCUMENT

BY AFFIDAVIT OF Jane Zabel Waxman

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Chester K Brown

Signature of Student Embalmer

Licensed Embalmer No. 4931

P. O. Address C C Mc

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