URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-040045

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5422

ENDED

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: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Johnson
c. CITY OR TOWN Shawnee — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7310 Larson — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Infant Middle Melinda Last Kay Ferrette
4. DATE OF DEATH: Month 11 Day 10 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-8-1959
9. AGE (last birthday): IF UNDER 1 YEAR Months Days 2; IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (City and state or country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Leo Ferrette
13b. MOTHER'S MAIDEN NAME: Given Taylor
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): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Leo Ferrette Address: 7310 Larson Shawnee, Kansas

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 — INTERVAL BETWEEN ONSET AND DEATH: Birth
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Immaturity 26 wks.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Baby 1 lb-14 oz. 14 wks. premature
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 COUNTY STATE

21. I attended the deceased from Birth, to death and last saw her him alive on 11/10/59
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert S. Brown (Degree or title) MD
22b. ADDRESS 4706 Broadway
22c. DATE SIGNED 11/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-12-1959
23c. NAME OF CEMETERY OR CREMATORY: Benld Cemetery
23d. LOCATION (City, town, or county) (State): Benld, Illinois

24. FUNERAL DIRECTOR: Mellody-McGilley-Eylar ADDRESS: 20 W. Linwood K.C. Missouri
25. DATE RECD. BY LOCAL REG.: 11-11-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert S. Brown

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 Wm H Gentry

Licensed Embalmer No. 503

P. O. Address K. C. M

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