URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-040075

STATE FILE NUMBER

FILED VS NOV 30 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5250

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 19 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys
Inside Limits Yes ☒ No ☐

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

3. NAME OF DECEASED (Type or print) First Tina Middle DeAnn Last Grolbert
4. DATE OF DEATH Month Nov. Day 1 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Oct 13-59
9. AGE (last birthday) IF UNDER 1 YEAR Months Days 19 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
11. BIRTHPLACE (City and state or country) Kansas City, Mo
12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME William Grolbert
13b. MOTHER'S MAIDEN NAME Bonnie Carbaugh
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 William Grolbert Address Waldron, Mo.

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) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Trachea-esophageal fistula — Since Birth
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. ☐ 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 11-1-59 and last saw her alive on 11-1-59
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF R. D. Dwyer

22a. SIGNATURE R D Dwyer (Degree or title) MD
22b. ADDRESS 1806 Swift Ave. North K. City, Mo
22c. DATE SIGNED 11/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov 4-59
23c. NAME OF CEMETERY OR CREMATORY Walnut Grove
23d. LOCATION (City, town, or county) Parkville (State) Mo

24. FUNERAL DIRECTOR Leland & Francis ADDRESS Parkville Mo
25. DATE RECD. BY LOCAL REG. 11-2-59
26. REGISTRAR'S SIGNATURE Nera Minshall

(Licensed Embalmer's Statement on Reverse Side)

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 m

~~or by~~ _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Leland K. Francis
401 main
Licensed Embalmer No. 3451
P. O. Address Parkville

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.