

**MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS JAN 19 1960 149**

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 6284-59-046751 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>7 hrs.</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Conley Maternity Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3448 E. 7th</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>GASTON</b>			4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/21/59</b>	9. AGE (last birthday) <b>Newborn</b>
		IF UNDER 1 YEAR Months <b>6</b> Days <b>50</b>	IF UNDER 24 HR Hours <b>6</b> Min. <b>50</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Donald Ray Gaston</b>		13b. MOTHER'S MAIDEN NAME <b>Karon Kay Andrews</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Karon Kay Andrews</b>		Address <b>3448 E. 7th.</b>
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) <b>Prematurity &amp; Immaturity</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Atelectasis</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>premature infant</b>			
20c. TIME OF INJURY Hour <b>—</b> Month, Day, Year <b>—</b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>11-21-59</b> to <b>11-22-59</b> and last saw her/him alive on <b>11-22-59</b> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>S. Misasi</b> (Degree or title) <b>D.O.</b>			22b. ADDRESS <b>3031 Indep. Ave. K.C. Mo.</b>		22c. DATE SIGNED <b>11-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>11/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>K. C. College of Osteopathy &amp; Surgery, K. C., Mo.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>K.C. College of Osteopathy, K.C. Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-31-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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