

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001920

FILED VS FEB 15 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 551 STATE FILE NUMBER # 2592

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>JACKSON</u> |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>KANSAS CITY</u>  |   | Length of stay in 1b<br><u>18 DAYS</u>  |  | c. CITY OR TOWN<br><u>KANSAS CITY</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><u>Doctors Hospital</u>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                   |   | d. STREET ADDRESS<br><u>7309 Blue Parkway</u>                                    |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Richard Allen Stewart</u>   |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>JAN 29 1960</u>  |  |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>1-11-60</u>  | 9. AGE (last birthday)<br>IF UNDER 1 YEAR<br>Months Days Hours Min.<br><u>18</u> |  | IF UNDER 24 HR  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>INFANT</u>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>   |   | 11. BIRTHPLACE (City and state or country)<br><u>KANSAS CITY Mo</u>              |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>CARL STEWART</u>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>PATRICIA SMITH</u>   |   |  | NAME OF HUSBAND OR WIFE<br><u>NONE</u>   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |   | 17. INFORMANT<br><u>CARL STEWART, KANSAS CITY, Mo</u><br>Address                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Toxemia</u><br>DUE TO (b) <u>Eclampsia of pregnancy of mother</u><br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>19 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Prematurity</u>  |   |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour a.m. p.m. 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 <u>Jan 11 1960</u> to <u>Jan 29 1960</u> and last saw him alive on <u>Jan 29 1960</u><br>Death occurred at <u>5:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |   |  |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>H.F. Stolarski DO</u>   |   |   |  | 22b. ADDRESS<br><u>2501 - Gillham Kansas City</u>   |  | 22c. DATE SIGNED<br><u>1-30-60</u>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |   | 23b. DATE<br><u>1-30-60</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>-</u>   |   | 23d. LOCATION (City, town, or county) (State)<br><u>Troy, Kansas</u>             |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>SIDMON'S MORTUARY, KANSAS CITY, Mo.</u>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>1-30-60</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Neva Marshall</u>  |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. F. STOLARSKI

**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 John R. Sidman

Licensed Embalmer No. 453  
P. O. Address Kansas City

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