RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-015362

STATE FILE NUMBER

FILED VS APR 25 1960 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1914

DED

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: 10 min.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Joseph 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: Overland Park
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 9719 Grandview
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: — Last: Harlan

4. DATE OF DEATH: Month 3 Day 28 Year 60

5. SEX: Boy
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3/28/60
9. AGE (last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min. 10 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): St. Joseph Hospital, Kansas City Mo.
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: George W. Harlan (initial only)
13b. MOTHER'S MAIDEN NAME: Catherine Jean Rasmussen
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: Catherine Jean Harlan — Address: 9719 Grandview, Overland Park, Kansas

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): PREMATURITY and IMMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes
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)
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 3-28-60, to 3-28-60 and last saw her/him alive on 3-28-60
Death occurred at 6:44 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Leo F. Cooper (Degree or title) MD
22b. ADDRESS: 1220 E. 31st K.C. 9, MO
22c. DATE SIGNED: 3-29-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Retained
23b. DATE: 3.28.60
23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Hosp.
23d. LOCATION (City, town, or county) (State): Kansas city mo.

24. FUNERAL DIRECTOR: Hospital Disposition — ADDRESS: St. Joseph Hospital K.C. Mo
25. DATE RECD. BY LOCAL REG.: 4-4-60
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Leo F. Cooper

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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