RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-015473

FILED VS. MAY 16 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2401 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Missouri — Length of stay in 1b 4 hr. 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 Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 419 Tennessee — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Michael Middle LeRoy Last Livings
4. DATE OF DEATH Month 4 Day 28 Year 60
5. SEX Male
6. COLOR OR RACE white
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 4-28-60
9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours 4 Min. 10
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) Kansas City Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Donald Livings
13b. MOTHER'S MAIDEN NAME Georgia Ann Long
14. NAME OF HUSBAND OR WIFE —
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 Mrs Georgia Livings Address 419 Tennessee

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 (28 weeks) (Anoxia)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cause Undetermined
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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 4:30 PM, to 8:40 PM and last saw her/him alive on 4-28-60
Death occurred at 8:40 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] Miller MD
22b. ADDRESS 4706 Broadway K.C. Mo.
22c. DATE SIGNED 4-29-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-30-60
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet
23d. LOCATION (City, town, or county) (State) Kansas City Mo.

24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home K.C. Mo.
25. DATE RECD. BY LOCAL REG. 4-29-60
26. REGISTRAR'S SIGNATURE Neva Menshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Gerald L. Miller

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Thomas A. Shiel

Signature of Student Embalmer

Licensed Embalmer No. 4954

P. O. Address K.C. Mo

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