URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-015657

STATE FILE NUMBER

FILED VS APR 26 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2004

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 Life
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hosp. — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3632 Woodland — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Infant Middle: Stringer Last:
4. DATE OF DEATH Month 4 Day 6 Year 60
5. SEX Female
6. COLOR OR RACE Negro
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 3-30-60
9. AGE (last birthday) IF UNDER 1 YEAR Months Days 6 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) K.C., Mo.
12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Clarence Stringer
13b. MOTHER'S MAIDEN NAME Vertice Mays
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. No
17. INFORMANT Clarence Stringer Address 3632 Woodland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage & Prematurity
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 4-5-60 to 4-6-60 and last saw her/him alive on 4-6-60
Death occurred at 8:03 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H L Dwyer MD (Degree or title)
22b. ADDRESS 2405 Cherry
22c. DATE SIGNED 4-7-60

BY AFFIDAVIT OF Dwyer MD

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-9-60
23c. NAME OF CEMETERY OR CREMATORY Lincoln
23d. LOCATION (City, town, or county) (State) KC Mo

24. FUNERAL DIRECTOR Watkins Bros. ADDRESS 10th & Benton
25. DATE RECD. BY LOCAL REG. 4-8-60
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

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 Bruce R. Watkins

Licensed Embalmer No. 450

P. O. Address 18th & Bente

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.