

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 17 1960

3027-60-023214
STATE FILE NUMBER

Registration District No. 1A9 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b <i>Life</i>		c. CITY OR TOWN Lee's Summit		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Conley Maternity Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2136 Grant St.		
3. NAME OF DECEASED (Type or print) First DONALD		Middle KEITH		Last HOSLER		4. DATE OF DEATH Month May Day 10 Year 1960		
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/9/60		
				9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours 7 Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Gerald Hosler			13b. MOTHER'S MAIDEN NAME Waketta Longacre			14. NAME OF HUSBAND OR WIFE Waketta Hosler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Waketta Hosler Lee's Summit, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Immaturity								
DUE TO (c) Prematurity								
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? 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 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 5/9/60 , to 5/10/60 and last saw ^{her} him alive on 5/10/60 Death occurred at 12:05 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>William J. Rhoads MD</i>				22b. ADDRESS 320 S. Douglas Lee's Summit		22c. DATE SIGNED 5/13/60		
23a. BURIAL, CREMATION REMOVAL (Specify) Anatomical		23b. DATE 5/10/60		23c. NAME OF CEMETERY OR CREMATORY K. C. College of Osteopathy & Surgery, K. C., Mo.		23d. LOCATION (City, town, or county) (State) 5/10/60		
24. FUNERAL DIRECTOR Conley Hosp. K. C. Mo.				25. DATE RECD. BY LOCAL REG. June 6, 1960		26. REGISTRAR'S SIGNATURE <i>Neil Minshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF WILLIAM J. RHOADS

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.