

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-023228

FILED VS. JUL 5 1960

149

Registration District No. Primary Registration District No. 1002

Registrar's No. 3280

STATE FILE NUMBER

UNDECEASED

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>                           |  | Length of stay in 1b<br><b>21 hrs</b>  | c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>QUEEN OF THE WORLD HOSPITAL</b> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>2617 INDIANA</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>INFANT JONES #1</b>                                      |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JUNE 16, 1960</b>            |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b> | 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><b>6/15/60</b>                                    | 9. AGE (last birthday)<br><b>21</b>                                | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>21 31</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired)<br><i>infant</i>            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>KANSAS CITY, MO.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                          |   |
| 13a. FATHER'S NAME<br><b>JIMMIE JONES</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>DARLENE NELSON</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><i>none</i>                         |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)<br><i>no</i> |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  |   | 17. INFORMANT Address<br><b>DARLENE JONES, MOTHER 2617 INDIANA</b> |   |

|   |  |  |
|---|--|--|
| 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) <b>CONGENITAL ENTERATRIAL SEPTAL DEFECT</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>PREMATURITY</b>                     |  | 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.<br>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 <b>6-15-60</b> , to <b>6-16-60</b> and last saw her/him alive on <b>6-16-60</b><br>Death occurred at <b>2:16 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Albert M. Crocker M.D.</b>   |   | 22b. ADDRESS<br><b>2202 1/2 E. 31st St.</b>  | 22c. DATE SIGNED<br><b>6/20/60</b>                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>6-25-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln</b>   | 23d. LOCATION (City, town, or county)<br><b>K.C., Mo.</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Watkins Bros. Funeral Home 18th &amp; Benton</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>6-21-60</b>   | 26. REGISTRAR'S SIGNATURE<br><b>new Marshall</b>          |

DOCUMENT

BY AFFIDAVIT OF Albert M. Crocker, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dwight R. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Pent

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.