

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 17 1960

60-023249

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3030

1. PLACE OF DEATH a. COUNTY <u>Jackson County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>(USA) Jackson</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>	Length of stay in 1b <u>25 hrs. 35 min</u>	c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2908 Campbell</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Kelly</u> Middle <u>louise</u> Last <u>Kline</u>			4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>60</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-5-60</u>	9. AGE (last birthday) <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	IF UNDER 24 HR Hours <u>25</u> Min. <u>35</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Charles Herbert Kline</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Louise Hibbs</u>	14. NAME OF HUSBAND OR WIFE <u>_____</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mary Louise Kline</u>	Address <u>2918 Campbell</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Prematurity (6 mo.)</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Placenta Previa (marginialis)</u>	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. 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.)
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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
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21. I attended the deceased from <u>6-5-60</u> to <u>6-6-60</u> and last saw her/him alive on <u>6-6-60</u>	
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>M.M. Geraghty</u> (Degree or title)	22b. ADDRESS <u>12101 E. New 40 highway Ind</u>	22c. DATE SIGNED <u>6/6/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>_____</u>	23d. LOCATION (City, town, or county) <u>Clinton, Mo.</u>
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24. FUNERAL DIRECTOR <u>Charles Mortuary, Clinton Mo</u>	ADDRESS <u>_____</u>	25. DATE RECD. BY LOCAL REG. <u>June 6, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF M. M. Geraghty 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 \_\_\_\_\_ or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed John R. Decker  
Licensed Embalmer No. 453  
P. O. Address Kansas

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