

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

-60-034686

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4750

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>21 Min.</u>		c. CITY OR TOWN <u>Hickman Mills</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>St. Joseph Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>11315 Booth</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>Anne</u> Last <u>Clyburn</u>				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>60</u>					
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>9-17-60</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
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		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph William Clyburn</u>				13b. MOTHER'S MAIDEN NAME <u>Shirley Joan Hollis</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
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>Joseph William Clyburn - Hickman Mills Mo.</u> Address <u>11315 Booth -</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown Hydrops fetalis</u>								INTERVAL BETWEEN ONSET AND DEATH	
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. <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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		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 <u>12:19 P.M.</u> to <u>12:40 P.M.</u> <u>9/17/60</u> and last saw her/him alive on <u>9/17/60</u> Death occurred at <u>12:40</u> <u>9</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Leo F. Cooper M.D.</u>				22b. ADDRESS <u>1220 E. 31st K.C. Mo</u>				22c. DATE SIGNED <u>9-19-60</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-18-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>-</u>		23d. LOCATION (City, town, or county) <u>Ik South Ks</u>		(State)	
24. FUNERAL DIRECTOR <u>Thine + McClure, Kansas City Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-19-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>			

BY AFFIDAVIT OF Signed Statement of Physician  
MEDICAL CERTIFICATION  
LEO F. COOPER

Mr. Leo C



**STATEMENT BY LICENSED EMBALMER**

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

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

Signed William McTee

Licensed Embalmer No. 46

P. O. Address Kansas City

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