

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

149

6091

-60-045973

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6091

DED

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) Kansas City			Length of stay in 1b Life	c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8516 Oldham Rd		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle BRENT Last CHILDERS				4. DATE OF DEATH Month December Day 4 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 11/5/60	9. AGE (last birthday) 1 Months 19 Days	IF UNDER 1 YEAR Months Days	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) Kansas City Mo		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Phillip Childers			13b. MOTHER'S MAIDEN NAME Carole Baum		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Phillip Childers 8516 Oldham Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse peritonitis DUE TO (b) Intestinal obstruction DUE TO (c) Strangulated small intestine in rt inguinal hernia						INTERVAL BETWEEN ONSET AND DEATH 4 days 8 days 3 days	
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 type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.			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 11/25/60 to 12/4/60 and last saw him alive on 12/4/60 Death occurred at 10:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert E. Allen, M.D.				22b. ADDRESS 200 Plaza Fine Bldg. Kansas City, Mo		22c. DATE SIGNED 12/5/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/6/60	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) Kansas City Missouri		(State)
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo				25. DATE RECD. BY LOCAL REG. 12-5-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer	

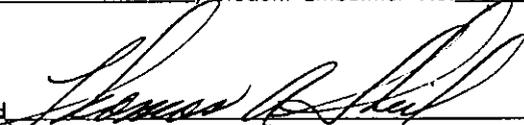
DOCUMENT

BY AFFIDAVIT OF ROBERT E. ALLEN 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  _____

Licensed Embalmer No. 4956

P. O. Address K.C.M.

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.