

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2093-61-017813
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2093

FILED MAY 17 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 8 hrs 17 min
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Jackson
c. CITY OR TOWN Overland Park Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 5800 W 100th St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Infant Boy Taber

4. DATE OF DEATH Month Day Year
4 - 20 - 61

5. SEX male 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 4-19-61 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min. 8 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Kansas City Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ROBERT LOUIS TABER 13b. MOTHER'S MAIDEN NAME MARTHA ANN DeGRAFF 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) 16. SOCIAL SECURITY NO. Y 17. INFORMANT MARTHA TABER 5800 W 100th Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity (due July 30) INTERVAL BETWEEN ONSET AND DEATH birth
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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 birth 4/19/61 to 4/20/61 and last saw him alive on 4/19/61
Death occurred at 5:10 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George Herrman MD 22b. ADDRESS 411 Nichols Rd 22c. DATE SIGNED 4/20/61

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Retained 23b. DATE 4-20-61 23c. NAME OF CEMETERY OR CREMATORY Hospital Dispense 23d. LOCATION (City, town, or county) (State) Kansas City Mo.

24. FUNERAL DIRECTOR St. Luke's Hosp. K.C. Mo. ADDRESS St. Luke's Hosp. K.C. Mo. 25. DATE RECD. BY LOCAL REG. 4-27-61 26. REGISTRAR'S SIGNATURE Reith Long

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF George Herrman

ITEM NO. SHOULD READ

-e157

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 Hospice Services, Student Embalmer No. _____,
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed [Signature] M.D.

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.